No. 90-1281

Supreme Court, U.S.
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In The

Supreme Court of the United States

October Term, 1990

BARRY GLEICHER and BIOPHARMACEUTICS, INC., formerly PATIENT MEDICAL SYSTEMS CORP.,

Petitioners,

vs.

UNITED STATES OF AMERICA,

Respondent.

APPENDIX

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APPENDIX A — SECOND CIRCUIT DENIAL OF PETITIONS FOR REHEARING FILED NOVEMBER 9, 1990

UNITED STATES COURT OF APPEALS

for the

SECOND CIRCUIT

At a stated Term of the United States Court of Appeals for the Second Circuit, held at the United States Courthouse in the City of New York, on the 9th day of November, one thousand nine hundred and ninety.

Present:

HON. J. EDWARD LUMBARD,

HON. JOHN M. WALKER, JR.,

HON. DANIEL M. FRIEDMAN*

Circuit Judges

Docket Nos. 89-1434, 89-1444

UNITED STATES OF AMERICA,

Appellee,

-v-

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* Judge Daniel M. Friedman, of the United States of Court of Appeals for the Federal Circuit, sitting by designation.

Appendix A

STEVEN B. WEISS, BARRY GLEICHER, PATIENT MEDICAL SYSTEMS CORP., a/k/a "INTEGRATED GENERICS, INC.", and HEALTH-MED, INC.,

Defendants,

PATIENT MEDICAL SYSTEMS CORP., a/k/a "INTEGRATED GENERICS, INC.," BARRY GLEICHER,

Defendants-Appellants.

A petition for a rehearing having been filed herein by Appellant BARRY GLEICHER,

Upon consideration thereof, it is

Ordered that said petition be and it hereby is DENIED.

s/ Elaine B. Goldsmith
Elaine B. Goldsmith
Clerk

Appendix A

UNITED STATES COURT OF APPEALS

for the

SECOND CIRCUIT

At a stated Term of the United States Court of Appeals for the Second Circuit, held at the United States Courthouse in the City of New York, on the 27th day of November one thousand nine hundred and ninety.

Present:

HON. J. EDWARD LUMBARD,

HON. JOHN M. WALKER

HON. DANIEL M. FRIEDMAN*

Circuit Judges,

Docket No. 89-1434(L), 89-1444

UNITED STATES OF AMERICA,

Appellee,

-v.-

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* Judge Daniel M. Friedman, of the United States of Court of Appeals for the Federal Circuit, sitting by designation.

Appendix A

STEVEN B. WEISS, BARRY GLEICHER, PATIENT MEDICAL SYSTEMS CORP., a/k/a "INTEGRATED GENERICS, INC.," and HEALTH-MED. INC.,

Defendants,

-and-

PATIENT MEDICAL SYSTEMS CORP., a/k/a "INTEGRATED GENERICS, INC.," BARRY GLEICHER,

Defendants-Appellants.

A petition for a rehearing having been filed herein by Appellant PATIENT MEDICAL SYSTEMS CORP.

Upon consideration thereof, it is

Ordered that said petition be and it hereby is DENIED.

s/ Elaine B. Goldsmith
Elaine B. Goldsmith
Clerk

APPENDIX B — SECOND CIRCUIT DECISION FILED SEPTEMBER 19, 1990

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

No. 781-782 August Term, 1989

Argued: April 11, 1990 Decided: SEP 19 1990

Docket No. 89-1434, 89-1444

UNITED STATES OF AMERICA,

Appellee,

-against-

STEVEN B. WEISS, BARRY GLEICHER, PATIENT MEDICAL SYSTEMS CORP., a/k/a "INTEGRATED GENERICS, INC," and HEALTH-MED, INC.,

Defendants,

-and-

PATIENT MEDICAL SYSTEMS CORP., a/k/a "INTEGRATED GENERICS, INC.," BARRY GLEICHER,

Defendants-Appellants.

Before: LUMBARD, WALKER, and FRIEDMAN,* Circuit Judges.

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* Daniel M. Friedman, of the United States Court of Appeals for the Federal Circuit, sitting by designation.

Appendix B

Appeal from the judgments of the United States District Court for the Eastern District of New York, Wexler, Judge, entered on a jury verdict, convicting the appellants of mail fraud, mail fraud conspiracy, and making false representations of material facts on Medicare and Medicaid claims, in violation of 18 U.S.C. § 1341 and § 371 (1988) and 42 U.S.C. § 1395nn(a)(1) and § 1396h(a)(1) (1982), respectively.

Affirmed.

MICHAEL J. HOROWITZ, Washington, D.C. (Jonathan R. Moore, Windels, Marx, Davies & Ives), for Defendant-Appellant Barry Gleicher.

MARTIN B. ADELMAN, P.C., New York, New York, for Defendant-Appellant Patient Medical Systems Corp., a/k/a "Integrated Generics, Inc."

JON M. BEVILACQUA, Special Assistant United States Attorney, Brooklyn, New York (Andrew J. Maloney, United States Attorney, and Kevan Cleary, Assistant United States Attorney, Brooklyn, New York), for Appellee.

FRIEDMAN, Circuit Judge:

In this appeal the appellants Gleicher and Patient Medical Systems Corp., a/k/a "Integrated Generics, Inc." ("Patient Medical"), challenge on various grounds their criminal convictions after a jury trial in the United States District Court for the Eastern District of New York of mail fraud, mail fraud conspiracy, and making false representations of material facts on Medicare and

Medicaid claims. The third convicted defendant, Weiss, had not been sentenced at the time this appeal was argued, and therefore did not join in the appeal.

The indictment, filed in July 1988, charged the three defendants named above and Health-Med, Inc. ("Health-Med"), a predecessor corporation of Patient Medical, with a conspiracy from February 1983 to December 1986, to defraud and to obtain money from the Health and Human Services Administration by means of false and fraudulent pretenses and representations. The indictment alleged that "[t]he object of the conspiracy was" "to obtain federal funds by and through the fraudulent submission of Medicare Claim Forms to Ohio, Illinois and New Jersey Medicare carriers for services with a 'point of sale' in New York, in order to receive the higher rate of Medicare reimbursement paid by these out-of-state carriers," and that pursuant to the conspiracy the defendants "submitted[] Medicare Claim Forms to the Ohio, Illinois, and New Jersey Medicare carriers, knowing that these Medicare Claim Forms should have been submitted to New York Medicare carriers."

Following the jury convictions, the district court sentenced Gleicher to three years' imprisonment, followed by five years' probation, and fines and a court assessment totaling $126,900. The court sentenced Patient Medical to fines, prosecution costs, and court assessments totaling $173,650.

I

A. *The Statutory and Regulatory Scheme for the Payment of Medicare Claims.*

Under Part B of Medicare, providers of "medical and other

health services," which include providers of "durable medical equipment . . . used in the patient's home . . . whether furnished on a rental basis or purchased," 42 U.S.C. § 1395x(s)(6), are entitled to reimbursement for the reasonable cost of providing such services. 42 U.S.C. § 1395k(a)(2)(B). One example of such "durable medical equipment," for which reimbursement is available, is the "rental or purchase of a medically necessary seat lift when prescribed by a physician for a patient . . . ." *Medicare Carriers Manual,* § 60-8.

Within the Department of Health and Human Services (the "Department") the Health Care Financing Administration (the "Administration") is responsible for the administration of part B of Medicare. Reorganization Order effective March 8, 1977. The Administration has promulgated the Medicare Carriers Manual (the "Manual"), which is the official explanation of the Medicare statute and the regulations.

Pursuant to statutory authority, 42 U.S.C. § 1395u(a), the Secretary has entered into contracts with entities throughout the country to process and pay Medicare claims. There are 47 such entities, known as carriers, each of which is responsible for paying claims in a specified geographic area.

Each individual carrier sets the amount it will pay for a particular service. As a result, the amounts the different carriers will pay for the same service may vary from carrier to carrier. The Manual explains the basis upon which a provider of services is to determine to which carrier it should submit a claim:

> Jurisdiction of payment requests for services of a supplier . . . with branch offices or sales/rental outlets in more than one carrier's jurisdiction lies

> with the carrier for the location where the service is furnished to the beneficiary whether or not the supplier uses a central billing office. (This means the site where the company met with the beneficiary or received the beneficiary's call.) All claims for the services of suppliers from branch officers or sales/rental outlets outside the carrier's service area must be transferred to the appropriate carrier for processing.

Manual, § 3102.B, at 3-63.2 - 3-64.1. The Manual provides "EXAMPLES OF MULTI-CARRIER JURISDICTION," which explain in detail how this rule works. *Id.* at 3-64.1 - 3-64.3.

The "location where the service is furnished to the beneficiary," *i.e.*, the "site where the company met with the beneficiary or received the beneficiary's call," and which determines the carrier to which the claim should be submitted, is known in the Medicare field as the "point of sale."

In addition to being published in the Manual, the rules governing the carrier to which a claim should be submitted are also from time to time published by the carriers themselves, in publications they send to providers. *See, e.g., Medicare Newsletter for Durable Medical Equipment Suppliers,* at 8 (Nationwide Mut. Ins. Co., Ohio July 1981).

One of the carriers to whom Patient Medical submitted Medicare claims was Nationwide Insurance Company, the Medicare carrier for Ohio ("Ohio Nationwide"). In the regular course of business, Ohio Nationwide distributes bulletins to all durable medical equipment providers that are registered with it,

including Patient Medical. One bulletin, dated July 1981, explained:

> Processing jurisdiction for services of a supplier with branch offices or sales/rental outlets in more than one carrier's jurisdiction lies with the carrier for the location where the service is furnished to the beneficiary whether or not the supplier uses a central billing office — this means the site where the company met with the beneficiary or received the beneficiary's call. All claims for the services of suppliers from branch offices or sales/rental outlets outside the carrier's service area must be submitted to the appropriate carrier for processing.

Id. at 8. "[T]hat particular document [is] sent to all providers that bill [the] carrier" and "from time to time over the years . . . similar documents [are sent] to the providers explaining how to bill the carrier." Moreover, Ohio Nationwide "send[s] out current and past newsletters that are pertinent to that particular practice." At the time Health-Med first joined the Medicare program, Ohio Nationwide sent it a similar bulletin stating that "[t]he revised policy [of the Administration] stipulates that, effective with dates of service of July 1, 1977, jurisdiction is based on the *point of sale,* regardless of where the billing is being done," *Medicare Bulletin*, (Nationwide Mut. Ins. Co. undated) (emphasis in original). A similar notice was included in a December 1985 Blue Cross/Blue Shield of Illinois newsletter.

Form 1500 is the official form, prepared by the Administration and approved by the Office of Management and Budget, on which a provider submits a claim for reimbursement to a carrier. Each carrier has its own version of the Medicare form.

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Box 31 of the form asks for the "PHYSICIAN'S OR SUPPLIER'S NAME ADDRESS ZIP CODE" and "TELEPHONE NUMBER." The Manual states that the "[n]ame and address information is furnished to help carriers determine whether the physician/supplier of services can qualify for benefit payments, and as an aid in determining jurisdiction and referring the claim to the servicing carrier where appropriate." *Manual*, § 4011.8, at 4-15. The Commerce Clearing House ("CCH") reprints these instructions in one of its publications. *See Medicare and Medicaid Guide* (CCH), ¶ 10,275.08.

B. *The Facts of This Case.*

Viewing the facts most favorably to the government, which is the standard on appeal from criminal convictions, *see Glasser v. United States*, 315 U.S. 60, 80 (1942), *U.S. v. Vanwort*, 887 F.2d 375, 385 (2d Cir. 1989), there was evidence from which the jury could have found:

At least until 1984, Health-Med was in the business of providing durable medical equipment to individuals whom Part B of Medicare covered. Its corporate headquarters and primary place of business were at 222 Franklin Avenue, Franklin Square, New York. In August 1984, Health-Med ceased operations, but continued to submit bills to Medicare carriers through Patient Medical until January 1986. From 1983 to 1984, the defendant Weiss was the president of Health-Med.

The appellant Patient Medical was in the same business and had the same New York address as Health-Med. The appellant Gleicher, who had not been formally connected with Health-Med, was a vice president, treasurer, and director of Patient Medical. Weiss was a vice president of Patient Medical.

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When Health-Med ceased operations in 1984, Patient Medical hired all of its employees and continued to serve all of its customers. In addition, Patient Medical continued to submit bills for equipment Health-Med had provided.

Weiss and Gleicher first met in August 1983. Initially, they had a number of conversations about submitting Medicare bills. They discussed the use of computers for such billing. They continued to discuss Medicare billings from 1983 through 1986.

1. *Health-Med's Initial Submission of Claims to the New York Medicare Carrier and Subsequent Submission to the New Jersey Carrier.*

Initially, Health-Med submitted Medicare claims for the durable equipment it sold to New York residents to Blue Cross and Blue Shield of Greater New York ("N.Y. Blue Cross"), the carrier for the State of New York. In Box 31 of each Form 1500 on which Health-Med filed its claims it gave its address as:

220 FRANKLIN AVENUE
FRANKLIN SQUARE NY 11010

In October 1983, Health-Med began submitting its claims for seatlift chairs sold to New York beneficiaries to Prudential Insurance Company ("N.J. Prudential"), the carrier for the State of New Jersey. Ms. Weisz, a former employee of Health-Med and Patient Medical, was instructed by Weiss to file the claims with N.J. Prudential, instead of N.Y. Blue Cross, "because the reimbursement was higher."

Box 31 of the Form 1500's submitted to N.J. Prudential gave as Health-Med's address:

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43 EDWARD HART DRIVE
JERSEY CITY NJ 07303

The "TELEPHONE NO." listed in Box 31 was "800 645-6225." Health-Med's New Jersey stationery used the same address, and a New Jersey telephone number — (201) 355-3900. When Health-Med decided to file these claims in New Jersey, a label with the above New Jersey address was placed over its previously typed New York address, at the direction of Weiss.

Health-Med had a warehouse at 43 Edward Hart Drive in Jersey City, but no sales were made from that address. All mail sent to that address was forwarded to Health-Med's New York office at the Franklin Square address. All calls made to the New Jersey telephone number were call-forwarded to and answered at the Franklin Square location.

Following a random inspection of claims Health-Med had filed, N.J. Prudential, by letter dated June 7, 1984, addressed to Weiss at the New Jersey address, stated that Health-Med had been "submitting Medicare claims for supplies sold or rented to beneficiaries in the State of New Jersey, Illinois and New York." After quoting section 3201.B of the Manual, N.J. Prudential stated that "[i]n the future, we will only process those claims specifying the State of New Jersey as the point of sale" and that "[t]he claims for sales or rentals made in Illinois and New York should be sent to the appropriate Medicare Carrier for each of these States."

Weiss responded that "[o]ur New Jersey office handles sales for the immediate tri-state area," and stated that "as Health Med has grown in outer states, local sales offices have been gradually opened." He also stated that "[i]n New York, Health Med has

arrangements with a Service Bureau to handle data processing functions including claims printing."

If N.J. Prudential had known Health-Med had no salespersons based in New Jersey, and that all calls to the New Jersey telephone were call-forwarded to New York, N.J. Prudential would not have paid these claims.

The last check N.J. Prudential issued to Health-Med was dated February 15, 1985.

Gleicher also corresponded with N.J. Prudential about filing claims with it. In a letter dated March 31, 1984, with a New York City return address, Gleicher wrote:

> I am interested in becoming a supplier of medical supplies and medical equipment. Could you please mail to me an application to become a provider and the amount of reimbursement for the various approved medical supplies and equipment. In addition, please mail to me pertinent information regarding your services.

N.J. Prudential replied:

> Medicare makes payment according to the State in which the services were rendered. Therefore, since you are from New York, you should send any claims you have for New Jersey Medicare patients to your Carrier in New York.

2. *The Submission of Claims to the Ohio Carrier.*

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Following N.J. Prudential's refusal to accept Health-Med claims, Patient Medical, Health-Med's successor, began in March 1985 to submit claims to Nationwide Insurance Company ("Ohio Nationwide"), the carrier for the State of Ohio. In Box 31 of the Form 1500's, Patient Medical gave its address as

1614 MIRAMAR COURT
CINCINNATI OH 45237

It also gave a Cincinnati telephone number.

This Ohio address was the residence of Mrs. Lifshitz, a housewife and full-time mother with eight children. When an Ohio Nationwide employee visited the address, no medical supplies, equipment, or commercial signs were visible there. Mrs. Lifshitz worked for Patient Medical and Health-Med and ran an office, but not a sales office, for them. She had made two sales of catheters and related equipment for Health-Med. Mrs. Lifshitz did not process any of the claims Patient Medical submitted to Ohio Nationwide. All of such processing was done in New York at the Franklin Square location.

All telephone calls to the Cincinnati number were call-forwarded to the Franklin Square office in New York. All mail sent to Mrs. Lifshitz's address was forwarded to the New York address.

In a telephone conversation in June 1985, an Ohio Nationwide employee told Weiss that he needed to establish the point of sale for the claims Patient Medical had submitted to Ohio Nationwide. In response, Weiss "insisted that all of their contacts to Medicare beneficiaries originate from the distribution of their catalogue sent to physicians and nurses throughout the nation. Mr. Weiss stated

that there are some phone contacts, but that the phone contacts always originate from his Cincinnati office." Although Weiss initially "stated that [Patient Medical had] absolutely no sales offices or sales representatives outside Ohio or West Virginia . . . he corrected his statement by giving the name and address of their Los Angelos [sic] representative . . . ." Weiss stated that Patient Medical "had no sales officials or sales representatives in the state of New York."

Ohio Nationwide discovered "four claims which have been submitted to our office for processing" that should not have been submitted there. In a letter dated July 25, 1985, to Weiss, the manager of claims administration for Ohio Nationwide stated "[w]e are forwarding the claim matter back to you as we feel the processing lies under a different jurisdiction, in terms of the geographic location in which the items were supplied." Ohio Nationwide explained:

> Effective July 1, 1977, the Health Care Financing Administration revised its' [sic] policy regarding supplies furnished by organizations which have branch offices and/or sales representatives that bill through a centralized billing office. The previous policy stipulated that the Carrier having jurisdiction for the billing office would process all claims even if the particular supplies represented on that claim were provided in an area not within that Carrier's jurisdiction. The revised policy stipulates that, effective with dates of service July 1, 1977, jurisdiction is based on the point of sale, regardless of where the billing is being done.

Ohio Nationwide also indicated that its investigation determined

"that the supply was actually sold within the states in which the beneficiaries reside." To aid Patient Medical in correct billing, Ohio Nationwide gave Weiss the name and address for the proper carriers for those claims, *i.e.*, the New York and Florida carriers.

In a further investigation of Patient Medical, Ohio Nationwide Ascertained that "the sale of the equipment and supplies are not through Ohio but through New York." In an August 1985 letter to Weiss, Ohio Nationwide informed him that "all claims received by [its] office will be transferred to" N.Y. Blue Cross and "suggest[ed] that [Patient Medical] begin submitting [its] Medicare claims to" the latter.

In response, Patient Medical's comptroller requested that Ohio Nationwide send Patient Medical's claims back to its Cincinnati address and not to New York. Gleicher wrote most of this letter. Ohio Nationwide denied this request.

Ohio Nationwide issued its final check to Patient Medical on August 2, 1985.

3. *The Submission of Claims to the Illinois Carrier.*

After the Medicare claims submitted to Ohio Nationwide had been "kicked out," Gleicher ordered the computer programmer "to hold all Medicare bills that [Patient Medical] had printed for seat lift chairs and other supplies that were to go to the state of Ohio . . . ." Then, "[a]fter the initial waiting period while [Gleicher and Weiss] decided where to send the claims, [Gleicher] came in and told [the computer programmer] the claims would be sent to the State of Illinois."

Patient Medical then began to file claims with Blue Cross/Blue

Shield-of Illinois ("Illinois Blue Cross"), the carrier for the State of Illinois. In Box 31 of the Form 1500's, Patient Medical gave its address as

480 CENTRAL AVENUE
NORTHFIELD IL 60093

It also gave an Illinois telephone number.

Illinois Blue Cross determined that another Northfield address also given in Box 31 on some of Patient Medical's filings, 540 Frontage Road, was a small office, with two employees, and a virtually empty filing cabinet. Health-Med had given 8600 West Bryn Mawr, North Chicago, Illinois, as its address on the forms it had submitted to Illinois Blue Cross. Upon visiting this office, an Illinois Blue Cross employee was informed by the receptionist that "no one from Health Med ever was there," and that "generally she forwards their mail to an address in New York and if they receive any calls, she takes the message and telephones the messages over to their office in New York."

Illinois Blue Cross then refused to process any more claims of Patient Medical, and transferred all pending claims to New York Blue Cross because they were "submitted for New York beneficiaries residing in New York nursing homes . . . ." In informing Patient Medical of its decision, Illinois Blue Cross explained to Patient Medical the point of sale rule, and its reasons for rejecting these claims.

Illinois Blue Cross issued its final check to Patient Medical in August 1985.

In filing the claims with Illinois Blue Cross, Patient Medical

sent large mailing envelopes to its national sales manager in Illinois. These mailing envelopes were addressed to Patient Medical in Illinois and had the Franklin Square address in New York as a return address. Each large mailing envelope contained a number of smaller envelopes addressed to Illinois Blue Cross, which had a return address of 540 Frontage Road, Northfield, Illinois, which contained Patient Medical's claims for reimbursement. These envelopes addressed to Illinois Blue Cross were sent certified mail by a mailing service in Illinois.

4. *The Decision Where to File the Claims.*

Weiss, the only defendant to testify, stated that he was ignorant of the detailed regulations governing the filing of Medicare claims. He indicated that in filing the claims he followed the advice and recommendations of Gayle Uhlenburg, a former vice president of Health-Med.

Mrs. Uhlenburg, however, testified that although she signed the claim forms, she did so at the direction of Weiss. Another former Patient Medical employee, Ms. Estee Weisz, testified that Weiss and Gleicher decided to which Medicare carrier the claims should be submitted. Both the Manual and the CCH Medicare/Medicaid Guide were kept in Weiss' office. Both Weiss and Gleicher periodically looked at those volumes, and Weiss had numerous discussions with other employees at the office concerning the filing of Medicare claims.

5. The Financial Benefit to the Appellants.

A government auditor calculated that the appellants received from N.J. Prudential, Ohio Nationwide, and Illinois Blue Cross $198,753.48 more than they would have received had the claims

been submitted to and paid by N.Y. Blue Cross.

II

Both appellants contend that the Paperwork Reduction Act of 1980, 44 U.S.C. § 3501 - 3520 (1982) (the "Act"), bars their prosecution.

The Act states that one of its purposes is "to minimize the Federal paperwork burden for individuals, small businesses, State and local government, and other persons." 44 U.S.C. § 3501 (1). As the legislative history indicates, the Act was designed "to reduce and minimize the burden Government paperwork imposes on the public." S. Rep. No. 930, 96th Cong., 2d Sess. 2 (1980), *reprinted in* 1980 U.S. Code Cong. & Admin. News, 6241, 6242.

The keystone of the Act is the requirement that all federal agencies submit all "information collection requests" to the Director of the Office of Management and Budget for review. *See* 44 U.S.C. § 3507. If the Director approves the information collection request, he must give it a control number. *See* 44 U.S.C. § 3504. "An agency 'shall not conduct or sponsor the collection of information unless' the information collection request has been submitted to and approved by the Director, *see* 44 U.S.C. § 3507(a), and 'shall not engage in a collection of information without obtaining from the Director a control number to be displayed upon the information collection request,' *see* 44 U.S.C. § 3507(F)." *United States v. Smith*, 866 F.2d 1092, 1094 (9th Cir. 1989).

Section 3512, captioned "Public Protection," states:

Notwithstanding any other provision of law,

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> no person shall be subject to any penalty for failing to maintain or provide information to any agency if the information collection request involved was made after December 31, 1981, and does not display a current control number assigned by the Director, or fails to state that such request is not subject to this chapter.

The Act defines "information collection request" to mean

> a written report form, application form, schedule, questionnaire, reporting or recordkeeping requirement, or other similar method calling for the collection of information[.]

Form 1500, the official form for submitting Medicare claims, was approved by the Director and has a control number. At the time of the events in this case, however, the Secretary had not submitted the Manual to the Director for his approval, apparently on the theory that the Act did not cover it, and the Manual therefore did not bear a control number.

The appellants contend that the Manual was an "information collection request" that required the Director's approval before it could be used. that the Manual required that the point of sale be shown on Form 1500, and that section 3512 therefore precluded their conviction for filing false Form 1500's with the New Jersey, Ohio, and Illinois Medicare carriers.

Assuming without deciding that the Manual is an "information collection request" — an issue the parties vigorously dispute — and therefore required the approval of the Director of the Office of Management and Budget, that conclusion would

not warrant the reversal of the appellants' convictions.

Section 3512 bars the imposition of "any penalty" upon any person "for failing to . . . provide information to any agency . . . if the information collection request involved . . . does not display a current control number assigned by the Director . . . ." The gravamen of the crimes for which the appellants were convicted, however, was not "failing to . . . provide information," but knowingly providing false information. The addresses they gave in Box 31 of their Form 1500's to the New Jersey, Ohio, and Illinois carriers as the "supplier's . . . address" were not the addresses from which the sale was made, as Box 31 required them to state.

This statement was a deliberate misstatement, designed and intended to convince N.J. Prudential, Ohio Nationwide, and Illinois Blue Cross that they, and not New York Blue Cross, were the carriers that should process and pay the claims. The fact that it was the Manual that explained the proper address to be shown in Box 31, *i.e.*, the point of sale, did not convert the appellants' conviction into one for "failing to . . . provide information" covered by the Manual.

It was Form 1500, and not the Manual, that required the submission of the point of sale address in Box 31. The appellants' conviction resulted from the jury's determination, which the record fully supports, that the appellants knowingly provided false information in Box 31, in order to defraud the United States by obtaining higher payments for their seat lift chairs than they were entitled to and would have received had they submitted the claims to New York Blue Cross.

The present case stands in sharp contrast to *United States*

v. Smith, 866 F.2d 1092 (9th cir. 1989), upon which the appellants rely. In *Smith*, the defendants were convicted of working on mining claims in a national forest without first having filed a Plan of Operations with the Forest Service. A Forest Service regulation required the filing of such a plan; the regulation, however, did not bear a control number because the Director of the Office of Management and Budget had not approved it.

The court of appeals reversed the conviction. It held that

> [t]he Plan of Operations filing requirement is an information collection request that lacks a current control number. Consequently, [44 U.S.C. § 3512] by its terms prohibits the imposition of "any penalty" against the appellants, including criminal convictions, for their failure to comply with the Plan of Operations filing requirement.

866 F.2d. at 1099 (footnote omitted).

In *Smith*, the crime for which the defendants were prosecuted was failing to file with the Forest Service a Plan of Operations, as the regulation required. Once the court held that the regulation was an "information collection request," which did not bear a control number, it necessarily followed that section 3512 barred the defendant's conviction for "failing to . . . provide the information" to the Forest Service, *i.e.*, the Plan of Operations the regulation required. The crime in *Smith* was the failure to make any filing. The Ninth Circuit held that because the filing requirement was imposed by an information collection request (the regulation) that bore no control number, section 3512 barred the conviction.

In the present case, in contrast, the appellants filed what they were required to file — the Form 1500 — but made false statements on the form. They were convicted for making those false statements, not for failing to file at all. Section 3512 did not bar their convictions. *See* Funk, *The Paperwork Reduction Act: Paperwork Reduction Meets Administrative Law,* 24 Harv. J. on Legisl. 1, 77 n. 411 (1987) ("The Public Protection provision at most only protects a person from penalties for *failing* to file information. It does not protect one who files information which is false. *Cf.* 18 U.S.C. § 1001(1982))." (Emphasis in original.)

The Supreme Court dealt with a somewhat related question in *Dennis v. United States,* 384 U.S. 855 (1966). There the defendants had been convicted of conspiring to defraud the United States by filing false non-Communist affidavits with the National Labor Relations Board. The defendants contended that their conviction should be reversed because section 9 (h) of the Taft-Hartley Act, which required the filing of non-Communist affidavits before a union could utilize the procedures of the National Labor Relations Board, was unconstitutional. The Court found it unnecessary to reach the question, because the defendants could not "attack the constitutionality of § 9 (h)." 384 U.S. at 865.

The Court pointed out that the defendants "were indicted for an alleged conspiracy, cynical and fraudulent, to circumvent the statute. Whatever might be the result where the constitutionality of a statute is challenged by those who of necessity violate its provisions and seek relief in the courts is not relevant here. This is not such a case. The indictment here alleges an effort to circumvent the law and not to challenge it . . . . " *Id.* The Court stated: "This is a prosecution directed at petitioners' fraud. It is not an action to enforce the statute claimed to be unconstitutional." *Id.* at 867. The court quoted with approval

its statement in *Kay v. United States*, 303 U.S. 1, 6 (1938), where, in upholding a conviction for making false statements in connection with the Homeowners' Loan Act of 1933, without deciding whether the act was constitutional, the Court said: "When one undertakes to cheat the Government or to mislead its officers, or those acting under its authority, by false statements, he has no standing to assert that the operations of the Government in which the effort to cheat or mislead is made are without constitutional sanction." *Id.* at 866.

The reasoning of these cases is no less applicable to the present case. If, as those cases held, it is no defense to a charge of filing false statements that the statute requiring the filing is unconstitutional, *a fortiori,* it is no defense to a charge of filing false statements that the government document that prescribed the details of filing had not been approved by the Director of the Office of Management and Budget, as the Paperwork Reduction Act allegedly required.

The appellants aregue, however, that the Manual did not require giving the point-of sale address in Box 31. They point out that section 4105.5 of the Manual requires that such information be furnished in Box 24 of Form 1500. Section 4011.8, however, states that "name and address information" from "item 8" (which the CCH manual, as well as other parts of the Manual, indicate is now Box 31) "is furnished . . . as an aid in determining carrier jurisdiction and referring the claim to the servicing carrier where appropriate."

Moreover, the Manual stated that the carrier would use the information in Box 31 to determine whether it had jurisdiction over the particular claim. N.J. Prudential, Ohio Nationwide, and Illinois Blue Cross told the appellants that, based on the

information contained in the Form 1500, the carrier to which they should submit the claims was New York Blue Cross, which had jurisdiction over the New York point of sale of the seat lift chairs for which the appellants sought reimbursement. As the jury necessarily concluded, the appellants intentionally made false statements in the Form 1500's they filed with N.J. Prudential, Ohio Nationwide, and Illinois Blue Cross.

III

Patient Medical contends that prosecutorial misconduct requires reversal of its conviction. It argues that there were three major aspects of such misconduct. Patient Medical contends that the prosecutor improperly (A) developed and presented evidence with respect to Weiss' wealth and income, (B) made inflammatory comments in his opening statement and particularly in his summation with respect to the defendants' greed and interest in money, and (C) in his closing argument used an anti-Semitic description of the defendants.

A. As the government notes, in his direct testimony Weiss sought to portray himself and his family as virtually indigent and claimed that, since he had not personally profited from the alleged misconduct, he should not be punished. Weiss testified that the salary he was "supposed to receive" from Health-Med in the 1983 fiscal year was $35,000. The prosecutor intorduced Patient Medical's 1984 Fiscal year tax return, which showed that in that year Patient Medical had paid Weiss $73,000. Weiss also testified that he earned $87,000 from Patient Medical in 1987 and that in that year only one person at Patient Medical earned more than he did, namely, Mr. Berkowitz, who, according to Weiss, earned $350,000. The prosecutor then referred to a filing by Patient Medical with the Securities and Exchange Commission that did

not list Berkowitz in the table showing the cash compensation of executive officers.

The district court gave the jury two curative instructions that "this information is coming in as to credibility not in [as] evidence in chief, " and "it's not evidence, it's only on [sic] an attack of truthfulness of other things said. It is not evidence in chief." In its second curative instruction, given after the tax return was admitted, the court explained that "what I just allowed in is not proof of how much he made, it goes to credibility. You may not use it as evidence in chief in the case, only as to credibility."

With respect to Weiss' wealth, Patient Medical contends that the prosecutor improperly questioned Weiss about the value of his house, brought out that he owned a Cadillac and a Lincoln, and noted that in 1988 he had renovated a bedroom in his house at a cost of $50,000 to $70,000.

The district court did not abuse its discretion in admitting the evidence relating to Weiss' wealth and income, and that evidence did not improperly inject the issue of Weiss' wealth into the case. The court informed the jury that this evidence related only to Weiss' credibility and did not relate to the merits of the government's case. The evidence was relevant to the issue of credibility. The curative instruction was proper; it did not unduly emphasize the issue to the jury or imply that the court vouched for the impeaching evidence. Indeed, Gleicher's trial counsel initially had requested such an instruction.

B. In his opening statement, the prosecutor told the jury

> You will also learn that the motive for this practice, yes there's a motive for what they did,

> and the motive for this practice was that the New Jersey, Ohio and Illinois Medicare carriers paid a higher rate of reimbursement for seat lift chairs than the New York carriers [sic] did. Money, that was their motive in perpetrating this scheme, money, plain and simple, greed.
>
> . . . .
>
> The defendants, nevertheless, continued to submit their claims to carriers located out of New York State in order to get the higher rates and make more money. Corporate greed, all too familiar in this country today.

Patient Medical quotes only the last sentence of each paragraph.

In his summation, the prosecutor made several highly critical comments about the defendants. He stated that "money is what this case is all about, money," characterized the defendants as "merchants of greed, deceit and corruption," told the jury that "[g]reed, that's what this case is about," and stated: "Money is what they wanted; greed, fraud. 'Greed is good, ' that's the motto that they prepared. They didn't care about the Medicare beneficiaries and the system. They wanted that money. This program was a noble program and they shouldn't have acted that way and they shouldn't have stolen the government [sic] money."

Although, standing alone, some of this language is quite hyperbolic and inflammatory, in the context of the entire summation we cannot say that it was so prejudicial as to require reversal of Patient Medical's conviction. The prosecutor would

have been well advised to have been more restrained in what he described as his rhetorical flourishes. Nevertheless, viewed in their totality and in context, his comments did not so appeal to the prejudice of the jury as to deny Patient Medical a fair trial.

The challenged prosecutorial conduct in this case was far less serious and pervasive than that in *United States v. Stahl,* 616 F.2d 30 (2d Cir. 1980), upon which Patient Medical relies. There we reversed for prosecutorial misconduct a conviction for bribing an employee of the Internal Revenue Service. We concluded that the prosecutor.

> did in fact intend to arouse prejudice against the defendant because of his wealth and engaged in calculated and persistent efforts to arouse such prejudice throughout the trial. In addition, the prosecutor made several statements during the trial that were not supported by the evidence and may, in some instances, have been intentionally misleading.

Id. at 32.

The court gave examples of "the nature of the prosecutor's trial strategy — a strategy that obviously included a persistent appeal to class prejudice. Because such appeals are improper and have no place in a court room, . . . we are compelled to reverse." *Id.* at 32-33 (citations omitted). These included repeated references, during the interrogation of witnesses, "to the 'Park Avenue offices' of the various participants in this drama, an emphasis that had nothing whatever to do with defendant's guilt or innocence," and during the cross-examination of the defendant, the "delving into his estimated net worth (over $20 million) and how he had managed

to build up such a fortune." *Id.* at 32.

As we have indicated, any misconduct in the present case was far less serious and pervasive. Furthermore, here the evidence of guilt was strong and compelling, and the district court's curative instructions adequately corrected any possible prejudicial effect the prosecutor's statements might have had.

The determination whether there has been prosecutorial misconduct requiring reversal of a conviction "must be examined in the context of the trial to determine whether the prosecution's behavior amounted to prejudicial error." *United States v. Nersesian,* 824 F.2d 1294, 1327 (2d Cir. 1987) (citing *United States v. Young,* 470 U.S. 1, 11-12 (1975)), *cert denied,* 484 U.S. 957, 958 (1987) and 484 U.S. 1061 (1988). Considering all the circumstances here, we cannot say that a reversal is mandated.

C. At the beginning of his summation, the prosecutor stated:

> Now in my opening statement to you I told you that my opening was like a table of contents in a book and that it happened to organize for you and to give you an idea what was to follow. However, I didn't tell you the title of that particular book that was going to be presented to you. I'm sure by now you know the title of that book, and the title to that book is called the Merchant of Franklin Square and not New Jersey, and not Ohio and not 8600 West Bryn Mawr, Chicago.

The prosecutor also referred to "[t]he merchants of Franklin Square, that's where it was done."

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Patient Medical contends that these comments constituted "a veiled appeal to religious prejudice." Noting the similarity of the phrase the "Merchant of Franklin Square" to Shakespeare's play "The Merchant of Venice," with its unflattering portrayal of the Jew, Shylock, Patient Medical contends that because the individual defendants in this case were Jewish, the prosecutor's comments improperly injected an element of anti-Semitism into the trial.

We disagree. Since the major issue in the case was whether the defendants should have filed their Medicare claims with New York Blue Cross, the carrier for the state in which the seat lift chair sales were made and which was Patient Medical's principal place of business in Franklin Square, the prosecutor's comments were but a colorful figure of speech designed to dramatize the issue for the jury.

Indeed, Patient Medical's trial counsel apparently agreed with that view. In his summation, he stated:

> He [The prosecutor] calls them "Merchants of Franklin Square." I have no problem with that. They were merchants, "were," because by the government not paying they had to get out of that business. But I have no problem with the word "merchants" because they went into business to make money.

Patient Medical also alleges that there were several other instances of prosecutorial misconduct. We have examined the relevant portions of the transcript, conclude that the prosecutor's conduct was not improper, and see no need to address Patient Medical's contentions in any length.

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IV

Patient Medical argues that the district court's allegedly inconsistent application of Rule 16 of the Federal Rules of Criminal Procedure denied it a fair trial. According to Patient Medical, the district court refused to permit it to introduce in evidence a document to impeach prosecution witness Estee Weisz, because Patient Medical had not previously given the document to the prosecution, but permitted the prosecution to introduce a document it had not previously given to Patient Medical to impeach the defendants' witness Weiss.

The court's refusal to permit Patient Medical to introduce the document followed instances of Patient Medical's failure to turn over to the government documents it intended to use as evidence. There was no comparable default by the prosecution. Furthermore, the government had no reason to anticipate using the document, in which Weiss stated that Patient Medical's staff was "highly knowledgeable in medicare regulations," to impeach Weiss, until Weiss had testified that he was unfamiliar with the filing requirements for Medicare claims.

Considering all the circumstances, the district court did not abuse its discretion in its rulings relating to the introduction into evidence of documents that each side had not previously given to the other.

V

Gleicher challenges his conviction under five counts (counts 4, 5, 13, 14 and 18) relating to Health-Med's filing of false claims, on the ground that he was "never an employee, stockholder, owner or salesman of Health Med."

Gleicher, however, was an officer, director, and employee of Health-Med's successor, Patient Medical. He actively participated in the filing of Health-Med claims after Health-Med ceased to operate. All the Medicare claims at issue were filed long after Gleicher and Weiss had met and at a time when both were with Health-Med's successor. Finally, the evidence showed that Gleicher and Weiss had engaged in a conspiracy from 1983 to 1986 with respect to the improper filing of Medicare claims.

The evidence supports Gleicher's conviction on counts 4, 5, 13, 14, and 18.

VI

Finally, both appellants contend that the supervision of jury selection by the magistrate was unconstitutional in light of the Supreme Court's subsequent decision in *United States v. Gomez,* 109 S. Ct. 2237 (1989), invalidating the practice. To sustain the contention, however, a defendant must "object to the selection of the jury by a magistrate." *United States v. Wong,* 884, F.2d 1527, 1545 (2d Cir. 1989). *See also United States v. Ford,* 824 F.2d 1430, 1438-39 (5th Cir. 1987) (en banc), *cert. denied,* 484 U.S. 1034 (1988). Here, as the appellants concede, they did not so object. Accordingly, the contention is not open to them.

CONCLUSION

The judgments of the district court are affirmed.

The stay of the judgment with respect to Patient Medical's payment of the fines pending our decision on its appeal, which we granted shortly after this appeal was heard, is vacated.

APPENDIX C — INDICTMENT FILED JULY 5, 1988

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

CR. No. 88-0397

(Title 18, U.S.C.,§§ 371, 1341, 2 and 3623; Title 42, U.S.C., §§ 1395nn(a)(1) and 1396(h)(a)(1))

UNITED STATES OF AMERICA,

- against -

STEVEN B. WEISS, BARRY GLEICHER, PATIENT MEDICAL SYSTEMS, CORP., also known as INTEGRATED GENERICS, INC., and HEALTH MED INC.,

Defendants.

INDICTMENT

THE GRAND JURY CHARGES:

INTRODUCTION

HEALTH MED INC.

1. On or about February 8, 1983, the defendant HEALTH MED INC. was incorporated under the laws of the State of New Jersey. From approximately February, 1983 until the end of December, 1986, its business consisted of supplying durable medical equipment and disposable medical supplies to Medicare beneficiaries. It conducted this business at offices located at 220 Franklin Avenue, Franklin Square, New York.

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2. At all times relevant to this indictment, the defendant STEVEN B. WEISS was an employee and President of the defendant HEALTH MED INC.

B. PATIENT MEDICAL SYSTEMS, CORP., also known as INTEGRATED GENERICS, INC.

3. On or about August 13, 1983, the defendant PATIENT MEDICAL SYSTEMS, CORP., also known as INTEGRATED GENERICS, INC. ("PMS"), was incorporated under the laws of the State of Nevada. From approximately August, 1983 through December, 1986, its business consisted of supplying durable medical equipment and disposable medical supplies to Medicare beneficiaries. It conducted this business at offices located at 220 Franklin Avenue, Franklin Square, New York.

4. At all times relevant to this indictment, the defendant STEVEN B. WEISS was an employee and Vice President of PMS.

5. At all times relevant to this indictment, the defendant BARRY GLEICHER was an employee, Vice President and Treasurer of PMS.

C. BLUE CROSS/BLUE SHIELD OF ILLINOIS

6. At all times relevant to this indictment, the Medicare program in Illinois was administered by Blue Cross/Blue Shield of Illinois ("Blue Cross"), which is a Medicare carrier. Pursuant to a contract with the United States Department of Health and Human Services ("HHS"), Blue Cross served as a fiscal intermediary and authorized agent of HHS. Blue Cross was empowered to set the rates of Medicare reimbursement and to receive, analyze and pay claims for reimbursement filed by

suppliers of goods and services to Medicare beneficiaries.

D. NATIONWIDE MUTUAL INSURANCE COMPANY OF OHIO

8. At all times relevant to this indictment, the Medicare program in Ohio was administered by Nationwide Mutual Insurance Company of Ohio ("Nationwide"), which is a Medicare carrier. Pursuant to a contract with HHS, Nationwide served as a fiscal intermediary and authorized agent of HHS. Nationwide was empowered to set the rates of Medicare reimbursement and to receive, analyze and pay claims filed by suppliers of goods and services to Medicare beneficiaries.

E. PRUDENTIAL INSURANCE COMPANY OF NEW JERSEY

9. At all times relevant to this indictment, the Medicare program in New Jersey was administered by Prudential Insurance Company ("Prudential"), which is a Medicare carrier. Pursuant to a contract with HHS, Prudential served as a fiscal intermediary and authorized agent of HHS. Prudential was empowered to set the rates of Medicare reimbursement and to receive, analyze and pay claims filed by suppliers of goods and services to Medicare beneficiaries.

F. NEW YORK MEDICARE CARRIERS

10. At all times relevant to this indictment, the Medicare program in New York was administered by Blue Shield of Western New York Inc., Group Health Inc., and Empire Blue Cross Blue Shield, formally known as Blue Cross Blue Shield of Greater New York, pursuant to contracts with HHS. These Medicare carriers

served as fiscal intermediaries and authorized agents of HHS, empowered to set the rates of Medicare reimbursement and to receive, analyze and pay claims filed by suppliers of goods and services to Medicare beneficiaries.

G. PMS's and HEALTH MED's RECEIPT OF FEDERAL FUNDS THROUGH MEDICARE

11. At all times relevant to this indictment, Medicare, as provided in Title XVIII of the Social Security Act, Title 42, United States Code, Section 1395 *et seq.*, and the Regulations enacted pursuant thereto, was a health insurance program administered by HHS for individuals aged 65 years and older and for eligible individuals under 65 years of age who are disabled. Under this program, HHS pays the cost of certain health care expenses for these eligible individuals.

12. At all times relevant to this indictment, HHS paid the total cost of the Medicare program administered in Illinois, Ohio, New Jersey and New York. The Medicare carriers determined the rate of reimbursement to be paid to suppliers of medical goods and services to Medicare beneficiaries.

13. At all times relevant to this indictment, suppliers of Medicare goods and services were required to submit to Blue Cross, Nationwide, Prudential, as well as the New York Medicare carriers, a Health Care Financing Administration Form 1500 ("Medicare Claim Form") in order to receive reimbursement for goods and services they supplied to Medicare beneficiaries.

14. Pursuant to the HHS Medicare Carriers Manual, "(Manual)", which is provided to all Medicare suppliers, a carrier's jurisdiction to receive, analyze and pay Medicare claims, and the

basis for the carrier's calculation of the amount of reimbursement to which suppliers are entitled, is determined, in part, by the location where the service is furnished to the beneficiary, i.e. the location where the supplier meets with the beneficiary or receives the beneficiary's call for the supplier's services. This location is known as the "point of sale".

15. A Medicare provider is eligible to receive only the prevailing rate of reimbursement in the geographic location of the point of sale. Pursuant to the Manual, Medicare suppliers are required to file Medicare claims with the Medicare carrier located in the geographic location where the services were furnished, i.e., the point of sale.

16. The Medicare Claim Form requires the supplier to list its name and address. The Manual requires that suppliers with branch offices located in more than one carrier's jurisdiction identify on the Claim Form the address of the branch office actually supplying the service to the Medicare beneficiary. This basic information is required in order to assist the carrier in determining whether the claim is properly filed in the carrier's jurisdiction and whether the carrier has jurisdiction to receive, analyze and pay the claim. The Medicare Claim Form includes the supplier's certification that the claim submitted is true and accurate. The Form states that anyone who misrepresents or falsifies essential information therein is in violation of federal criminal law, and that anyone submitting any false claim or statement, or concealing a material fact, may be prosecuted under applicable federal or State law, or both.

17. In or about and between February, 1983 and December, 1986, the defendants STEVEN B. WEISS, BARRY GLEICHER, PMS and HEALTH MED INC., supplied and caused to be

supplied durable medical equipment and disposable medical supplies, with a "point of sale" in New York, to Medicare beneficiaries in the State of New York. However, the defendants filed and caused to be filed the Medicare Claim Forms with Medicare carriers in Illinois, New Jersey and Ohio, instead of filing them with the appropriate New York Medicare carriers. The defendants also misrepresented and caused to be misrepresented on the Medicare Claim Forms the address of the suppliers' branch office which actually supplied the aforesaid medical equipment and supplies to the Medicare beneficiaries. At all times relevant to the filing of these Medicare claims, the out-of-state carriers paid a higher rate of reimbursement than the rate paid by the appropriate New York Medicare carriers.

H. PMS's RECEIPT OF STATE FUNDS THROUGH MEDICAID

18. At all times relevant to this indictment, pursuant to the Medicaid Act, as provided in Title XIX of the Social Security Act, Title 42, United States Code, Section 1396 *et seq.*, HHS shared with each participating State the cost of providing medical services and goods to families with dependent children and to the aged, blind, needy, or permanently disabled individuals, whose income and resources were insufficient to meet the costs of necessary medical services. The Medicaid program further provided for rehabilitative and other services to help such eligible individuals. Included within this category of individuals eligible for Medicaid, are certain individuals who are also eligible for Medicare, for example, individuals aged 65 years and older, and certain other individuals under age 65 who are disabled. Where there is dual coverage of both the federal Medicare program and the State Medicaid program, the federal government, through its Medicare carriers, determines the rate of reimbursement to be paid to

suppliers of medical goods and services to the Medicare/Medicaid beneficiaries. The federal government is responsible for paying 80% of the federally approved amount, and the State is responsible for paying the remaining 20% of that federally approved amount.

19. Pursuant to the Medicaid Act, New York State promulgated a plan for the above-described medical assistance program. The New York State Department of Social Services contracted with the McAuto Systems Group Inc., ("McAuto") an insurance company located at 800 North Pearl Street, Menands, New York, to administer the Medicaid program in New York State.

20. At all times relevant to this indictment, McAuto was the fiscal intermediary and authorized agent of New York State, empowered to receive, analyze and pay Medicaid claims. These Medicaid claims were submitted to McAuto by suppliers of goods and services to Medicare/Medicaid beneficiaries.

21. At all times relevant to this indictment, the defendants STEVEN B. WEISS, BARRY GLEICHER, PMS and HEALTH MED INC., supplied and caused to be supplied durable medical equipment and disposable medical supplies to Medicare/Medicaid beneficiaries in New York State.

22. At various times relevant to this indictment, the defendants STEVEN B. WEISS, BARRY GLEICHER and PMS filed and caused to be filed inflated Medicaid claims with McAuto requesting the 20% reimbursement from New York State. These claims were inflated in that the amount claimed was based upon the higher rate of reimbursement fraudulently claimed on the corresponding Medicare claims.

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COUNT ONE

Paragraphs One through Fifteen and Eighteen through Twenty-Two are repeated and realleged as if fully set forth herein.

In or about and between February, 1983 and December, 1986 both dates being approximate and inclusive, within the Eastern District of New York and elsewhere, the defendants STEVEN B. WEISS, BARRY GLEICHER, PATIENT MEDICAL SYSTEMS, CORP., also known as INTEGRATED GENERICS, INC. ("PMS") and HEALTH MED INC., and others, knowingly, wilfully and unlawfully did combine, conspire and agree to violate Title 18, United States Code, Section 1341, that is, to use the mails and cause the use of the mails for the purpose of executing a scheme and artifice to defraud and to obtain money from the Health and Human Services Administration ("HHS") by means of false and fraudulent pretenses and representations.

The object of the conspiracy was (a) to obtain federal funds by and through the fraudulent submission of Medicare Claim Forms to Ohio, Illinois and New Jersey Medicare carriers for services with a "point of sale" in New York, in order to receive the higher rate of Medicare reimbursement paid by these out-of-state carriers, and (b) to obtain inflated New York State Medicaid reimbursement based upon the higher rate of reimbursement fraudulently obtained on the corresponding Medicare claims.

1. It was part of this conspiracy, scheme and artifice that the defendants STEVEN B. WEISS, BARRY GLEICHER, PMS and HEALTH MED would submit and cause to be submitted, Medicare Claim Forms to the Ohio, Illinois, and New Jersey Medicare carriers knowing that these Medicare Claim Forms should have been submitted to New York Medicare carriers.

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2. It was further part of this conspiracy, scheme and artifice that the defendants STEVEN B. WEISS, BARRY GLEICHER, PMS and HEALTH MED would submit and cause to be submitted Medicare Claim Forms to the Ohio and New Jersey Medicare carriers, instead of the appropriate New York carrier by mailing these Claim Forms from the defendants' Franklin Square, New York, offices directly to the Ohio and New Jersey Medicare carriers.

3. It was further part of this conspiracy, scheme and artifice that the defendants STEVEN B. WEISS, BARRY GLEICHER and PMS would devise an out-of-state mailing route for Medicare Claim Forms which were fraudulently submitted to the Illinois Medicare carrier, in order to conceal the true New York "point of sale" for the services supplied to New York Medicare beneficiaries.

4. It was further part of this conspiracy, scheme and artifice that Claim Forms for New York Medicare beneficiaries referred to in paragraph "3" above would be delivered from the New York offices of PMS to a PMS office in Illinois, together with pre-prepared mailing envelopes bearing the return address of the Illinois office. The Claim Forms were then mailed in the State of Illinois, in the pre-prepared envelopes, to the Illinois Medicare carrier, and were received by the Illinois carrier bearing Illinois post marks.

5. It was further part of this conspiracy, scheme and artifice that the defendants, STEVEN B. WEISS, BARRY GLEICHER, PMS and HEALTH MED would submit and cause to be submitted in excess of Four Hundred New York Medicare claims to out-of-state Medicare carriers, and in excess of One Hundred related Medicaid claims to the New York Medicaid carrier.

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6. It was further part of this conspiracy, scheme and artifice that the defendants STEVEN B. WEISS, BARRY GLEICHER, PMS and HEALTH MED would fraudulently obtain and cause to be fraudulently obtained approximately Two Hundred Thousand Dollars ($200,000) in excess Medicare reimbursement, and approximately Eight Thousand Dollars ($8,000) in excess New York State Medicaid reimbursement, by the fraudulent submission of Medicare claims to the out-of-state carriers.

In furtherance of said conspiracy and to effect the objects thereof, the defendants STEVEN B. WEISS, BARRY GLEICHER, PMS and HEALTH MED did commit and cause to be committed, within the Eastern District of New York and elsewhere, the following:

OVERT ACTS

(a) In or about and between February, 1983 and December, 1986, both dates being approximate and inclusive, the defendants STEVEN B. WEISS, BARRY GLEICHER, PMS and HEALTH MED supplied and caused to be supplied, within the Eastern District of New York and elsewhere, seat lift chairs to New York Medicare beneficiaries.

(b) In or about and between February, 1983 and December, 1986, both dates being approximate and inclusive, within the Eastern District of New York, the defendants STEVEN B. WEISS and BARRY GLEICHER instructed employees at the offices of the defendants PMS and HEALTH MED, located at 220 Franklin Avenue, Franklin Square, New York, to make modifications to their computer billing software.

(c) On or about March 31, 1984, the defendant BARRY

GLEICHER wrote a letter to Prudential Insurance Company, the New Jersey Medicare carrier.

(d) In or about August, 1985, within the Eastern District of New York, the defendants STEVEN B. WEISS and BARRY GLEICHER instructed an employee of the defendant PMS that the Ohio Medicare carrier stopped accepting and paying the PMS Medicare claims and instructed this employee to submit PMS Medicare claims to the Illinois Medicare carrier.

(e) On or about June 25, 1985, within the Eastern District of New York, defendant STEVEN B. WEISS advised a representative of Nationwide Mutual Insurance Company, the Ohio Medicare carrier, that all of PMS's contacts with Medicare beneficiaries originated from distribution of its sales catalogs sent to physicians and nurses throughout the nation.

(Title 18, United States Code, Sections 371 and 3623).

COUNTS TWO THROUGH SEVEN

Paragraphs One through Fifteen and Eighteen through Twenty-Two are repeated and realleged as if fully set forth herein.

In or about and between February, 1983 and December, 1986, both dates being approximate and inclusive, within the Eastern District of New York and elsewhere, the defendants STEVEN B. WEISS, BARRY GLEICHER, PMS and HEALTH MED, together with others, did knowingly and wilfully devise a scheme and artifice to defraud and to obtain money from Nationwide Insurance Company and HHS, through false and fraudulent pretenses and representations.

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1. It was part of said scheme and artifice that the defendants fraudulently submitted Medicare claims for their New York Medicare beneficiaries to the Ohio Medicare Carrier (Nationwide) in order to receive a higher rate of reimbursement than that to which the defendants were entitled, knowing that these claim forms should have been submitted to the appropriate New York Medicare Carrier.

2. For the purpose of executing this scheme and artifice, the defendants STEVEN B. WEISS, BARRY CLEICHER, PMS and HEALTH MED, did place and caused to be placed in a post office or authorized depository for mail matter within the Eastern District of New York, the following Medicare Claim Forms, addressed to Nationwide in Columbus, Ohio, to be sent and delivered by the Postal Service:

COUNT	MEDICARE CARRIER AND APPROXIMATE DATE OF MAILING	MEDICARE BENEFICIARY	CLAIM NUMBER	CLAIM AMOUNT PAID BY MEDICARE CARRIER
2	Nationwide 5/84	Girondo, V.	114128323040	$1,320.00
3	Nationwide 8/84	Clinton, V.	114241242130	$1,116.00
4	Nationwide 9/84	Sperbeck, 0.	114275509040	$1,116.00
5	Nationwide 10/84	Dellangelo, U.	114296276170	$1,356.00
6	Nationwide 2/85	Hastings, M.	115032374220	$1,116.00
7	Nationwide 6/85	Fillmore, V.	115175427240	$1,116.00

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(Title 18, United States Code, Sections 1341, 2, and 3623).

COUNTS EIGHT THROUGH TEN

Paragraphs Three through Six, Ten through Eighteen, and Twenty-One are repeated and realleged as if fully set forth herein.

On or about the dates listed below, within the Eastern District of New York and elsewhere, the defendants STEVEN B. WEISS, BARRY GLEICHER and PMS did knowingly and wilfully make and cause to be made false representations of material facts on Medicare Claim Forms submitted to Blue Cross Insurance Company, the Illinois Medicare carrier, in that such claims falsely represented that the supplier's address was 540 Frontage Road, Northfield, Illinois, whereas, in the truth and fact, as the defendants STEVEN B. WEISS, BARRY GLEICHER and PMS then and there well knew, the Medicare supplier's true address was 220 Franklin Avenue, Franklin Square, New York:

COUNT	MEDICARE CARRIER AND APPROXIMATE DATE OF RECEIPT BY CARRIER	MEDICARE BENEFICIARY	CLAIM NUMBER	CLAIM AMOUNT PAID BY MEDICARE CARRIER
8	Blue Cross 7/8/85	Wittenberg, E.	185189245260	$1,699.80
9	Blue Cross 8/26/85	Nadel, M.	185238162220	$1,699.80
10	Blue Cross 9/30/85	Greenwood, E.	185273822230	$694.48

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(Title 42, United States Code Section 1395 nn(1), and Title 18, United States Code, Sections 2 and 3623).

COUNTS ELEVEN THROUGH SIXTEEN

Paragraphs One through Five, Eight, Ten through Eighteen, and Twenty-One are repeated and realleged as if fully set forth herein.

On or about the dates listed below, within the Eastern District of New York and elsewhere, the defendants listed below did knowingly and wilfully make and cause to be made false representations of material facts on Medicare Claim Forms submitted to Nationwide Mutual Insurance Company, the Ohio Medicare carrier, in that such claims falsely represented that the Medicare supplier's address was 1614 Miramar Court, Cincinnati, Ohio, whereas in truth and fact, as said defendants then and there well knew, the Medicare supplier's true address was 220 Franklin Avenue, Franklin Square, New York:

COUNT	DEFENDANT	APPROXIMATE DATE OF RECEIPT BY MEDICARE CARRIER	BENEFICIARY	CLAIM NUMBER	CLAIM AMOUNT PAID BY MEDICARE CARRIER
11	Weiss, Gleicher, Health Med	5/7/84	Girondo, V.	114128323040	$1,320.00
12	Weiss, Gleicher, PMS	8/28/84	Clinton, V.	114241242130	$1,116.00
13	Weiss, Gleicher, Health Med	10/1/84	Sperbeck, O.	114275509040	$1,116.00
14	Weiss, Gleicher, Health Med	10/22/84	Dellangelo, U.	114296276170	$1,356.00
15	Weiss, Gleicher, PMS	2/1/85	Hastings, M.	115032374220	$1,116.00
16	Weiss, Gleicher, PMS	6/24/85	Fillmore, V.	115175427240	$1,116.00

Appendix C

(Title 42, United States Code, Section 1395 nn(1), and Title 18, United States Code, Sections 2 and 3623).

COUNTS SEVENTEEN AND EIGHTEEN

Paragraphs One, Two, Nine through Eighteen, and Twenty-One are repeated and realleged as if fully set forth herein.

On or about the dates listed below, within the Eastern District of New York and elsewhere, the defendants STEVEN B. WEISS, BARRY GLEICHER and HEALTH MED did knowingly and wilfully make and cause to be made false representations of material facts on Medicare Claim Forms submitted to Prudential Insurance Company, the New Jersey Medicare carrier, in that such claims falsely represented that the Medicare supplier's address was 43 Edward Hart Drive, Jersey City, New Jersey whereas in truth and fact, as the defendants STEVEN B WEISS, BARRY GLEICHER and HEALTH MED then and there well knew, the Medicare supplier's true address was 220 Franklin Avenue, Franklin Square, New York:

COUNT	APPROXIMATE DATE OF RECEIPT BY CARRIER	MEDICARE BENEFICIARY	CLAIM NUMBER	CLAIM AMOUNT PAID BY MEDICARE CARRIER
17	3/2/84	Gagne, M.	406200594	$912.00
18	2/8/85	Bartley, B.	503937733	$912.00

Appendix C

(Title 42, United States Code, Section 1395 nn(l), and Title 18, United States Code, Sections 2 and 3623).

COUNTS NINETEEN THROUGH TWENTY-ONE

Paragraphs Three through Five, Eleven, Twelve, and Fourteen through Twenty-Two are repeated and realleged as if fully set forth herein.

On or about the dates listed below, within the Eastern District of New York and elsewhere, the defendants STEVEN B. WEISS, BARRY GLEICHER and PMS did knowingly and wilfully make and cause to be made false representations of material facts on Medicaid Claim Forms submitted to McAuto Insurance Company, in that defendants STEVEN B. WEISS, BARRY GLEICHER and PMS inflated the amount of money to be reimbursed to PMS:

Appendix C

COUNT	APPROXIMATE DATE OF RECEIPT BY CARRIER	MEDICAID BENEFICIARY	CLAIM NUMBER	CLAIM AMOUNT PAID BY MEDICAID CARRIER
19	4/1/85	Phippen, S.	50912288037	$279.00
20	4/15/85	King, V.	51052217023	$279.00
21	4/26/85	Zalewski, M.	51162263033	$279.00

Appendix C

(Title 42, United States Code, Section 1396(h)(a)(i), and Title 18, United States Code, Sections 2 and 3623).

A TRUE BILL

s/ [illegible]
FOREPERSON

s/ Andrew J. Maloney
ANDREW J. MALONEY
UNITED STATES ATTORNEY
EASTERN DISTRICT OF NEW YORK

APPENDIX D - SAMPLE CLAIM FORM

HEALTH INSURANCE CLAIM FORM

READ INSTRUCTIONS BEFORE COMPLETING OR SIGNING FORM

☐ MEDICARE ☐ MEDICAID ☐ CHAMPUS ☐ OTHER

Form Approved
OMB No. 0938-0008

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (Last name, first name, middle initial, and suffix)

2. PATIENT'S DATE OF BIRTH

3. INSURED'S NAME (Last name, first name, middle initial, and suffix)

4. PATIENT'S ADDRESS (Street, city, state, ZIP code)

5. PATIENT'S SEX
MALE ☐ FEMALE ☐

6. INSURED'S I.D. NUMBER (MEDICARE AND/OR MEDICAID NO. if applicable)

7. PATIENT'S RELATIONSHIP TO INSURED
SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

8. INSURED'S GROUP NO. (Or Group name)

TELEPHONE NUMBER

9. OTHER HEALTH INSURANCE COVERAGE - Enter name of Policyholder and other name and address and Policy or Group Association number

10. WAS CONDITION RELATED TO
A. PATIENT'S EMPLOYMENT
YES ☐ NO ☐
B. AN ACCIDENT
AUTO ☐ OTHER ☐

11. INSURED'S ADDRESS (Street, city, state, ZIP code)

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I hereby authorize the Release of any medical or other information necessary to Process this Claim and Request Payment of MEDICARE Benefits Either to myself or to the Party who Accepts Assignment Below)

SIGNED DATE

13. I authorize Payment of Medical Benefits to UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW

SIGNED (Patient or Authorized Person)

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

15. DATE FIRST CONSULTED YOU FOR THIS CONDITION

16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS?
YES ☐ NO ☐

16a. IF AN EMERGENCY CHECK HERE ☐

17. DATE PATIENT ABLE TO RETURN TO WORK

18. DATES OF TOTAL DISABILITY
FROM THROUGH

DATES OF PARTIAL DISABILITY
FROM THROUGH

19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g., nurse, relative, agency)

20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES
ADMITTED DISCHARGED

21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (If other than home or office)

22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE?
YES ☐ NO ☐ CHARGES

23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC OR DX CODE

A.
1.
2.
3.
4.

B.
EPSDT YES ☐ NO ☐
FAMILY PLANNING YES ☐ NO ☐
PRIOR AUTHORIZATION NO.

24. A DATE OF SERVICE FROM	TO	B. PLACE OF SERVICE	C. PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	G. EPSDT Family Plan	H. LOCAL USE

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

26. ACCEPT ASSIGNMENT? (GOVERNMENT CLAIMS ONLY) (SEE BACK)
YES ☐ NO ☐

27. TOTAL CHARGE

28. AMOUNT PAID

29. BALANCE DUE

30. YOUR SOCIAL SECURITY NO

31. SIGNATURE OF SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO

32. YOUR PATIENT'S ACCOUNT NO

33. YOUR EMPLOYER I.D. NO

I.D. NO.

* PLACE OF SERVICE AND TYPE OF SERVICE (P.O.S.) CODES ON THE BACK REVERSE

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE, INC.
APPROVED BY THE HEALTH CARE FINANCING ADMINISTRATION & CHAMPUS

Form HCFA-1500 (C2) (10-
Form CHAMPUS-501.

BEST AVAIL

Appendix D

HEALTH INSURANCE CLAIM FORM

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 is completed, the patient's signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program and renders payment for health benefits provided through membership and affiliation with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned "Insured"; i.e., items 3, 6, 7, 8, 9 and 11.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE AND CHAMPUS)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally rendered by me or were rendered incident to my professional service by my employee under immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.*

For services to be considered as 'incident' to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that neither I nor any employee who rendered the services are employees or members of the Uniformed Services (refer to 5 USC 5536).

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR 422 510).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE AND CHAMPUS INFORMATION

We are authorized by HCFA and CHAMPUS to ask you for information needed in the administration of the Medicare and CHAMPUS programs. Authority to collect information is in section 205(a), 1872 and 1875 of the Social Security Act as amended and 44 USC 3101, 41 CFR 101 et seq and 10 USC 1079 and 1086.

The information we obtain to complete Medicare and CHAMPUS claims is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by Medicare or CHAMPUS and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards and other organizations or Federal agencies as necessary to administer the Medicare and CHAMPUS programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor.

With the one exception discussed below, there are no penalties under Social Security or CHAMPUS law for refusing to supply information. However, failure to furnish information regarding the medical service rendered or the amount charged would prevent payment of Medicare or CHAMPUS claims. Failure to furnish any other information, such as name or claim number, would delay payment of the claim.

It is mandatory that you tell us if you are being treated for a work related injury so we can determine whether worker's compensation will pay for treatment. Section 1877(a) (3) of the Social Security Act provides criminal penalties for withholding this information.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency, or Dept. of Health and Human Services may request. I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductibles and coinsurance.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally rendered by me or under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate, and complete.

I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

PLACE OF SERVICE CODES:

1 – (IH) – Inpatient Hospital
2 – (OH) – Outpatient Hospital
3 – (O) – Doctor's Office
4 – (H) – Patient's Home
5 – – Day Care Facility (PSY)
6 – – Night Care Facility (PSY)
7 – (NH) – Nursing Home
8 – (SNF) – Skilled Nursing Facility
9 – – Ambulance
0 – (OL) – Other Locations
A – (IL) – Independent Laboratory
B – – Other Medical/surgical Facility
C – (RTC) – Residential Treatment Center
D – (STF) – Specialized Treatment Facility

TYPE OF SERVICE CODES:

1 – Medical Care
2 – Surgery
3 – Consultation
4 – Diagnostic X-Ray
5 – Diagnostic Laboratory
6 – Radiation Therapy
7 – Anesthesia
8 – Assistance at Surgery
9 – Other Medical Service
0 – Blood or Packed Red Cells
A – Used DME
M – Alternate Payment for Maintenance Dialysis
Y – Second Opinion on Elective Surgery
Z – Third Opinion on Elective Surgery

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APPENDIX E — EXCERPTS FROM RECORD ON APPEAL

[503] Albert-cross/Sale

* * *

CROSS-EXAMINATION BY MR. SALE [Attorney for Gleicher]:

Q. Good afternoon, Ms. Albert. My name is Robert Sale. I'm Barry Gleicher's attorney.

You testified earlier that PMS claims which referred to New York beneficiaries were forwarded by Nationwide to the New York carrier, is that true? A. Yes, we initiated a flag within the system to give these instructions.

Q. Is it not true, Ms. Albert, that there were numerous PMS claims for Ohio residents that were also returned to the New York carrier?

MR. BEVILACQUA [Special Assistant U.S. Attorney]: Objection, Your Honor.

THE COURT: I'll allow it.

A. I don't know because I didn't see the claims as they came in, so I can't really say any claim no matter where the patient was physically located would have been transferred to the New York carrier.

Q. You say you can't say whether they — A. Well, you are asking me if there were any Ohio claims or Ohio beneficiaries, correct?

Q. Yes. A. And if those claims were transferred to New York?

Q. Yes. [504] A. If we received them, yes, they would have been transferred.

Q. And it's correct—

MR. BEVILACQUA: Your Honor, I renew my objection at this point.

THE COURT: I'll allow it.

Q. And it's correct that you received many claims from PMS for Ohio residents, not just New York residents, but also Ohio residents; isn't that true? A. I'm aware there were a few but I wouldn't say many.

Q. Well, didn't you state in your report that the majority of the claims were for New York residents? A. Yes.

Q. And that means that the rest of them were not New York residents isn't that correct? A. Correct.

Q. So in the case of a New York resident with a Miramar Court address, how would you know where the point of sale was in that claim that you transferred to the New York carrier?

MR. BEVILACQUA: Objection.

THE COURT: Haven't we gone over this? I know, not by you, but by everybody else.

Q. Let me ask you this question, Ms. Albert. Did you ever have any contact with my client, my client is Barry Gleicher, in this case? A. No.

Appendix E

* * *

[893] Nisnewitz-direct/Bevilacqua

* * *

Q. Would you explain to the jury what the term "disposable medical supplies" means? A. Those are medical supplies disposed of such as catheters, irrigation devices, things of that nature.

Q. Could you explain to the jury, briefly, the term "durable medical equipment"? A. Durable medical equipment, a piece of that is a piece of equipment that a beneficiary would use because of the specific illness or because they have an illness, like it's a hospital bed, a seat lift chair, a cane, things of that nature.

Q. And do vendors provide durable medical equipment and disposable medical supply equipment to Medicare beneficiaries? A. Yes, they do.

Q. Do you know what an "assigned claim" is? A. That is a claim in which a physician or a supplier agrees to accept the amount that Medicare determines to be the approved amount as the reimbursement.

Q. And those particular claims I showed you with respect to seat lift chair claims submitted by defendants Patient Medical Systems Corporation and Health Med, are they assigned claims? A. They all were assigned claims, yes.

* * *

Appendix E

THE COURT: Haven't we heard what a seat lift chair is

* * *

[900] Nisnewitz-direct/Bevilacqua

* * *

BY MR. BEVILACQUA:

Q. I direct your attention to box 31 on the 1500 claim form. If a Medicare supplier has more than one office address, which address must be placed in box 31? A. The address for the branch office where the services were furnished or the "point of sale" as we say.

Q. That is pursuant to the Medicare carrier's manual? A. Yes, it is.

Q. What section? A. That would be section 4105.5 which was formerly 4105.8.

Q. Is there a telephone number that is required to be placed in that box as well? A. Yes, there is.

Q. What significance is there with respect to requiring that telephone number? A. The telephone number is used to facilitate development on the part of the carrier.

Q. The carrier can contact the suppliers? A. Exactly. It just makes it easier.

Q. I direct your attention to Medicare manual section 4011.8. Does this section require — what does this section require, if [901] anything? A. The title of the section is Name and Address of Physician or Supplier and basically it requires that the supplier indicate the name and address as well as a telephone number on the claim form.

* * *

[902] Nisnewitz-cross/Werfel

* * *

CROSS-EXAMINATION BY MR. WERFEL [Attorney for PMS]:

Q. Good morning, Ms. Nisnewitz. A. Good morning.

Q. I'm David Werfel. I'm the attorney for Patient Medical Systems.

Ms. Nisnewitz, how would somebody get a Medicare carrier's

manual? A. Well, they would call the carrier and ask them for a specific section. They could go visit the carrier and look at the manual if they wanted to.

Q. But what if they want a manual? A. They could call up, I assume, the Government Printing Office and get a copy of the manual.

Q. Do you know how much they would have to pay for it? A. I have no idea, no.

Q. But it's not given to them free, is it? [903] A. No, it's not?

A. But they could get specific sections if they wanted to, as I say.

Q. If somebody is starting up a business and they just want to have the manual, they don't know what section to ask for since they are brand new; is that correct? A. That would be correct, probably.

Q. So if they wanted to get the manual, they would have to purchase it? A. Yes, they would.

Q. Now, if a supplier sends claim forms to the wrong carrier, what is the obligation of that carrier, the one who receives it? A. If it's an individual, what they would normally do, if it's an assigned claim they would return it to the supplier and indicate that they should send it to the appropriate carrier on individual cases.

Q. Has that always within been the law.

Appendix E

Withdrawn.

Has that always been a provision of the Medicare manual? A. My recollection, yes.

Q. Did you bring a Medicare manual with you today? A. I think one is available. I did not physically carry one here today, no.

* * * *

[1008] Thompkins-direct/Bevilacqua

Q. Pursuant to that contract, was your carrier empowered to receive, analyze and pay claims filed by suppliers of goods and services to Medicare beneficiaries? A. Yes.

Q. Now, sir, you know what a seat lift chair is; is that right? A. Yes, I do.

Q. Would you tell the jury, please, what the allowable rate of reimbursement was for seat lift chairs from the period July — I'm sorry, from the period July 1, 1983, through June 30, 1984? A. Okay. There are several allowances. First allowance will be $900 for 1983 to '84.

Q. Now, let me ask you for the next period.

July 1, 1984, through September 30, 1985, what was the allowable rate for seat lift chairs? A. $1420.

Q. From the period of time October 1, 1985 through December 31, 1986, what was the allowable for seat lift chairs? A. $860.

Appendix E

MR. BEVILACQUA: Thank you, Mr. Thompkins.

(Continued)

[1009] CROSS-EXAMINATION BY MR. WERFEL:

Q. Mr. Thompkins, are you aware how your rates compare to Empire Blue Cross and Blue Shield? A. In some fashion, yes, I'm aware.

Q. Are you aware that the rate that you just gave us from July 1 of 1983 through June 30, 1984, that 900 figure, is the same as that one paid by Blue Cross/Blue Shield of Greater New York? A. Yes.

Q. Are you also aware that the following year, July 1 of '84 through September 30, 1985, actually it's a little bit more than one year, you were paying 1420 — you were allowing 1420, but Blue Cross/Blue Shield of New York was only allowing 954 during that same period, are you aware of that? A. I wasn't aware of their allowance at that time period. I know our allowance happened to be for that time period.

Q. Okay.

No other questions.

* * *

Appendix E

* * * *

[1136] Carney-Cross/Werfel

document.

MR. WERFEL: If we have different listings we show different overpayment.

THE COURT: Don't they realize it's not applied or it's a new thing or they added to it, what does it have to do with this?

MR. BEVILACQUA: Precisely.

THE COURT: You start out with one and you are set for life, can't change it.

MR. WERFEL: I think the theory changed in the middle of the prosecution from point of sale to point of residence.

THE COURT: You haven't established anything about that, just because they have a different list. I mean we all draw up lists on things and add and subtract. What does that prove?

MR. WERFEL: After an indictment is given to defense counsel, it's not the time to change the theory.

MR. BEVILACQUA: It is not. Based upon her review of the testimony, the exhibits, the point of sale in this case was the home.

THE COURT: Let's proceed.

(End side bar).

Q. Do you recognize that listing? That's my question.

THE COURT: Asked and answered. It looks familiar. She probably drew it up.

[1137] Q. When you drew it up, what did you use to determine whether or not there was an overpayment? Did you use point of sale, patients' residences? A. Considering address was the point of sale. These documents were only a draft, the ones you showed me.

Q. That's only a draft? A. It's not a final copy.

Q. Okay.

I have no other questions.

MR. KUNKEN: No questions.

THE COURT: You may step down.

Next witness.

MR. BEVILACQUA: I actually have one question on redirect, Your Honor?

THE COURT: Okay.

REDIRECT EXAMINATION BY MR. BEVILACQUA:

Q. Auditor Carney, earlier Mr. Werfel had mentioned two

Appendix E

Medicare beneficiary's names to you that weren't included in this indictment — withdrawn — in this trial. They weren't part of the 577 claims. Will you tell the jury, please, approximately what the underpayment was for those two underpayments we didn't include?

MR. WERFEL: Objection.

THE COURT: Overruled.

* * *

[1146] [Sidebar discussion]

* * *

MR. FEITELL [Attorney for Weiss]: I would join in the defendant Weiss so far as the application relates to him. Above and beyond the OMB claim the Administrative Procedure Act also has bearing here and that was raised in the initial motions, Judge. The manual was not approved under the Administrative Procedure Act, not only OMB.

Now, on the issue of conspiracy, there's no testimony in the case from any witness that there was any agreement or understanding between the parties that what they were doing was incorrect or wrong so there was no intention on the part of anyone to deceive or to defraud. I say there's a legal insufficiency of proof on the intent to deceive.

THE COURT: You mean the parties have to do something wrong in order to do a conspiracy? So if Mafia A meets with Mafia B, and they work out an agreement and they say

nothing is wrong —

MR. FEITELL: No circumstantial evidence of an intent to deceive.

THE COURT: Denied.

* * *

[1504] Closing statement-Bevilacqua

* * *

Now at the outset I want to take this opportunity to thank each and every one of you for fulfilling your duty as trial jurors. I realize you were selected in early April and we did not commence to take testimony until early May. So on behalf of Andrew J. Maloney, the United States Attorney for the Eastern District of New York, my superior, and myself, I want to thank you for your jury service.

Your service as trial jurors is very important to the criminal justice system. We can't function without you.

Now in my opening statement to you I told you that my opening was like the table of contents in a book and that it happened to organize for you and to give you an idea what

was to follow. However, I didn't tell you the title of that particular book that was going to be presented to you. I'm sure by now you know the title to that book, and the title to that book is called the Merchant of Franklin Square and not New Jersey, and not Ohio and not 8600 West Bryn Mawr, Chicago.

Now, you've heard several carrier representatives testify before you that in order to properly bill a Medicare carrier, a supplier needs two things. The first thing that the supplier must [1505] have is an office in that carrier's jurisdiction. And the second thing that that supplier must have is that the product he's billing to the carrier must be sold in that carrier's jurisdiction. That's what is referred to by people in the health care industry as the point of sale rule.

It's a rather logical rule, this point of sale rule, and it's very easy to understand and it's very clear.

Now, that's what is important in this particular case and that's what you have to remember.

What this case involves is 577 seat lift chair claims for New York Medicare beneficiaries which was submitted to the Medicare carriers in the states of New Jersey, Ohio and Illinois.

Now you may be told that the defendants did not hide this Franklin Square address from the carriers in those states.

However, the fact that their headquarters are in New York is meaningless. Why is it meaningless? Because they misled the carriers as to where the point of sale was. New Jersey, Ohio, Illinois, West Bryn Mawr, those were not offices. They had an office at 540 Frontage Road, however you heard the employees

come in and tell you they didn't sell any seat lift chairs there. The people from Ohio and Illinois told you that the seat lift chairs were not sold in their geographic areas. We know from the salesmen, the salespeople in this case, that those seat lift chairs were sold in the [1506] state of New York.

Now, there are three sections of the Medicare carrier's manual which we are concerned in this particular case. The first one is Government's Exhibit 46 A, 3102.B, the second one from the Medicare carrier manual 4105.8 and the fourth one is 4011.8. These three charts are in evidence and you may read them and refer to them if you wish. 3102.B defines point of sale. 4011.8 discusses the use of the supplier's address in determining the appropriateness of the carrier's jurisdiction, and of course by now we all know as to what famous box relates, don't we. I won't even mention the numbers 4105.8, this is the third section, if you recall, that Dale Bates, Mr. Bates from Ohio came in here and he told you that the defendant Steven Weiss quoted this section almost verbatim when he said that, yes, I had beneficiary addresses outside your carrier's area.

However, I have solely catalogue sales, and under the Medicare carrier manual section 4105.8, I can show addresses outside your area because he had New York beneficiary addresses which were outside the Ohio carrier's address.

Now, of course, he told you the defendant didn't have salesman outside the area. Of course you know that the defendant did have salesmen, we brought them in, and you heard about the investigation.

The defendant Weiss misrepresented the facts to Mr. [1507] Bates, the carrier representative.

Appendix E

Now in my opening statement that I made to you I advised that I was going to produce a number of Medicare carrier witnesses who were going to tell you about their investigation of the defendants and that they had advised the defendants by letter of the appropriate Medicate billing instructions, the Medicare carrier's manual section.

These letters are very important to this case. You know, the ancient Romans had a maxim, and the maxim was "The spoken word may fly away, however, the printed word endures forever." And these letters from the Medicare carriers and the bulletins sent to the defendants Weiss and Gleicher are what helps establish their guilt beyond a reasonable doubt. It's written and it's there for to you take a look at.

These letters that you've heard about through the carrier witnessess, the former Health Med and PMS employees testify about, put the defendants on notice of the proper Medicare billing instructions and they help to establish the defendants' guilt in this particular case of all the crimes charged.

I would like to review with you these documents. What I want to do is start with the New Jersey carrier chronologically.

* * *

[1520]

* * *

Do you remember you needed two things, an office and

a point of sale. Health Med in Illinois, no office, no point of sale. Now for PMS in Illinois, there's an office, but the goods weren't sold in Illinois. So again PMS couldn't bill Illinois either. Why? Because all of these claims, all 577 for these seat lift chairs were sold in the state of New York.

Now, the seat lift chair is a rather noble thing. Our government, as you know, and you heard a discription of the Medicare program pays for physician services in certain situations, it's a program for everybody over 65, regardless of your income. Medicaid is based on your income, if you fall below a certain level then you get Medicaid as well as Medicare.

But our government in addition to paying physician services fees, and they created this seat lift policy, made it reimbursable, as a quality of life item, to help people in their daily living who are afflicted with serious disease, who are afflicted with such things as severe arthritis of the hips, muscular dystrophy, neuromuscular diseases. Here was a very noble thing the government did. They didn't have to do this but they did, to make life a little easier for those who suffered from these things.

MR. SALE: I object to this.

* * * *

[1156] Forte-direct/Werfel

THE COURT: I don't know why we need this.

MR. WERFEL: I feel it's important for PMS, Your Honor. It shows that New York would only process New York patients, contrary to what this case is all about. If the objection

is founded based on the dates of the claims, I would go right into that to lay a foundation.

MR. BEVILACQUA: This is all irrelevant, Judge.

THE COURT: This is a letter sent by them based upon conversation by you which I don't know what the conversation is.

Mr. WERFEL: I will not ask him about the conversation.

THE COURT: Objection sustained.

MR. BEVILACQUA: Here are the letters that Mr. Werfel will no go into next. Letters he wrote to the carrier. This is my relevancy.

THE COURT: Next.

MR. WERFEL: Your Honor, assuming I further go down with the foundation, you are saying I can't get this letter in.

THE COURT: At the present time you cannot get it in.

MR. WERFEL: All right.

(End side bar).

BY MR. WERFEL:

Q. Mr. Forte, the claims that were in the cartons, do you know what dates they were? [1157] A. As far as dates, range from 1984 into early '86, I believe.

Q. And were these claims for patients who lived in New York? A. They were for patients who lived throughout the United States, including New York.

Q. Did you process those claims? A. Not at that time.

Q. Did you subsequently process those claims?

MR. BEVILACQUA: Your Honor, I object to this.

THE COURT: Overruled.

A. Yes, we eventually processed those claims.

Q. Did you process those claims after first contacting anybody outside of Blue Cross/Blue Shield? A. Yes, the regional office of the Health CAre Financing Administration.

Q. And when you processed the claims, did you process the claims for New York beneficiaries as well as non-New York beneficiaries? A. That's correct.

Q. Did there come a time that you returned claims to me as the attorney for PMS? A. Yes, back with that letter of November of 1986.

Q. Why were claims returned to me? A. We had a telephone conversation that all these claims had been sent to New York and that there were beneficiaries throughout the United States with a provider whose address on [1158] the claim form was located in Illinois.

At that point upon discussions with my boss, we returned

all claims that had out of area beneficiary addresses, and upon further investigation we retained the claims that had New York beneficiary addresses.

Q. In sum, is it fair to say you processed those claims that had New York addresses for patients and returned the ones that did not have New York addresses? A. We returned the claims, I returned the claims to you and the others I did not process until I had instructions to process.

MR. WERFEL: Your Honor, I have no other questions. But again I renew my offer to admit the letter into evidence.

THE COURT: Any other questions?

I'm still not allowing it in.

MR. WERFEL: May I just have it marked for Identification?

(Continued)

APPENDIX E — EXHIBIT 19—LETTER DATED MAY 2, 1984 OF SCHIPANE

May 2, 1984

Barry Gleicher
530 Grand Street, Bldg. D.
New York, New York 10002

Dear Sir:

This letter is in response to your letter of March 31, 1984 to become a New Jersey Medicare Supplier.

Medicare makes payment according to the State in which the services were rendered. Therefore, since you are from New York, you should send any claims you have for New Jersey Medicare patients to your Carrier in New York.

Sincerely,

Mrs. E. Schipane
Enrollment Clerk
Medicaid Claim Division II

ES:RZ

APPENDIX E — EXHIBIT 10—LETTER DATED JUNE 7, 1984 OF HARVEY

June 7, 1984

Health Med., Inc.
45 Edward Hart Drive
Jersey City, N.J. 07305
Attn: Steven B. Weiss

Dear Mr. Weiss:

We recently conducted a randon sampling review of your claims. This made us aware of your office submitting Medicare claims for supplies sold or rented to beneficiaries in the States of New Jersey, Illinois and New York.

The Medicare Carrier Manual states "jurisdiction of payment request for services of a supplier with branch offices or sales/rental outlets in more than one carriers jurisdiction lies with the carrier for the location where the service is furnished to the beneficiary whether or not the supplier uses a central billing office". This means the site where the company met with the beneficiary or received the beneficiaries call. "All claims for the services of suppliers from branch offices or sales/rental outlets outside of the carriers service area must be transferred to the appropriate carrier for processing."

In the future, we will only process those claims specifying the State of New Jersey as the point of sale.

The claims for sales or rentals made in Illinois and New York should be sent to the appropriate Medicare Carrier for each of these States.

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At this time, we must request you to advise us of the functions performed by each of the facilities owned and operated by Health Med., Inc. in the States of New Jersey, Illinois and New York.

Your cooperation on these matters is appreciated.

Sincerely,

s/ CH
C. Harvey
Utilization Reviewer
Medical Administration

CH:mb

APPENDIX E — EXCERPTS FROM RECORD ON APPEAL

[4] [Excerpts from related civil trial]

THE COURT: Yes. What do you intend to pr ..?

MR. THOMPSON: In this matter, Your Honor, civil litigation was commenced to challenge the validity of certain provisions what has been referred to as the carrier's manual and I know your Honor is familiar with a lot of the terminology having sat through the criminal trial. There has been motions submitted earlier to the Court and the Court has indicated that this matter could proceed towards the eventual challenge of the provisions which it's our claim have been improperly used and have been promulgated improperly to the detriment of our client. The provisions that we are discussing and contained within the carrier's manual relate what was characterized during the criminal trial as "point of sale." And we will prove that there have been many definitions, none of which have been applied consistently.

We will prove that these provisions are only applicable to the carriers and we will prove that these provisions are in point of fact have been utilized improperly because they've never been approved by the APA nor OMB and that, accordingly, they are invalid and, hence, can be given no force and effect. Accordingly, the suspension of payments which occurred in conjunction with the supposed violation of these —

THE COURT: Wasn't that all tried in the criminal case [5] and didn't I make rulings on every one of those decisions?

MR. THOMPSON: Your Honor, those specific issues of law were never litigated. No conclusions of law with respect to those matters.

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THE COURT: You are saying I didn't rule on those issues?

MR. THOMPSON: There was never any evidence produced in the criminal trial with respect to the APA.

THE COURT: What is that?

MR. THOMPSON: Administrative Procedure Act which is a requirement that any substantive provision must be published in the Federal Register before it can be binding and have any effect.

THE COURT: You didn't talk to Mr. Werfel then because he did offer proof on that.

MR. THOMPSON: There was never any decision that I've seen.

THE COURT: Did you read the record?

MR. THOMPSON: Yes, I did, Your Honor.

THE COURT: If he was right, there wouldn't have been a conviction.

MR. THOMPSON: Well, Your Honor --

THE COURT: I would have to dismiss it. Did I dismiss the case?

MR. THOMPSON: No sir.

[6] THE COURT: Okay.

MR. THOMPSON: However, Counsel has indicated in their moving papers that the question of the validity of the provisions was determined by the jury. However, in the criminal trial the government took the position that the validity of the provisions was not the — the linchpin was not what the case was all about.

Moreover, Counsel has indicated that the jury decided the issue of the validity of the regulations and I would submit that the jury had no authority to determine the issue of the validity of the regulations, that that's a matter for the Court. And I would further submit while there were motions made there was never any dispositive decision related to that issue.

THE COURT: What do you say?

MR. CLEARY: Your Honor decided that issue. There were papers put in in the criminal case and Your Honor decided the issue of whether the carrier's manual required OMB approval. The question was, it was an information collection request. The carrier's manual itself is not an information collection request, however the form is and that's why the form has an OMB number. Your Honor ruled on that and understands why they are not—

THE COURT: I made specific rulings on those points. I remember it.

MR. THOMPSON: Your Honor —

[7] THE COURT: I don't have the record but I remember it.

MR. CLEARY: I have the record and it will take me

five, ten minutes to find it. If it's true then obviously the criminal indictment would have had to have been thrown out.

THE COURT: If I made rulings on it is it res judicata.

MR. CLEARY: I understand.

MR. THOMPSON: My understanding of the criminal trial —

THE COURT: No, if I made specific rulings on that issue, is it binding.

MR. THOMPSON: I do not believe that the issues that we are going to litigate today have been presented in the criminal trials.

THE COURT: What issues? I want the issues succinctly put forth that are still open and I made rulings on.

Number one.

MR. THOMPSON: Whether or not the provisions of the carrier's manual require APA approval.

THE COURT: Provisions of carrier's manual require what?

MR. THOMPSON: APA approval.

THE COURT: What does that stand for?

MR. THOMPSON: Administrative Procedures Act.

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THE COURT: — Approval.

* * *

[17] Dombi-direct/Thompson

THE COURT: Did I make a ruling based upon that?

THE WITNESS: I'm unaware of it. Your Honor, I was here only for my testimony at that time.

Q. I would like to show you two letters, if I may?

MR. CLEARY: If I may see the letters.

THE COURT: If there were no rules and regulations, there could be no fraud.

THE WITNESS: Your Honor, I guess that is a decision for this Court.

THE COURT: That's right. And this Court ruled by submitting it to the jury, not on the issue, but whether there was fraud, accepting the rules and regulations as valid. Otherwise it couldn't go to a jury. And I just pulled out my jury charge that I gave to the jury in May of '89.

Proceed.

MR. THOMPSON: Thank you, Your Honor.

THE COURT: —Where I did not give the issue to the jury to make the determination, I made the determination.

MR. THOMPSON: I might point out again, Your Honor, if I may, that defense counsel in their papers for summary judgment have indicated that the jury determined the issue of the validity of the regulations.

THE COURT: Yes. You can look at my charge. Obviously you have a copy in the court reporter's but I have the exact charge here, the one I gave. There is no

* * *

[37] Dombi-direct/Thompson

Q. Mr. Dombi, if there is a failure to obtain APA approval, what is the effect upon that regulation? Does it in fact become void? A. A rule which is not promulgated through the Administrative Procedure Act is void.

Q. And —

THE COURT: So there was no regulations here and therefore no fraud. Back to the same thing. And Judge Wexler was wrong when he ruled as he did.

MR. THOMPSON: Well, in fact, Your Honor, our claim —

THE COURT: It's that simple, right.

THE WITNESS: Yes, Your Honor.

THE COURT: I know, it has to be that way. If there are no rules and regulations, there cannot be any fraud, it's that

simple. I ruled there was regulations and let the jury decide if there was fraud.

Continue.

MR. THOMPSON: Thank you, sir.

* * *

APPENDIX E — EXHIBIT II—J. PLAGER OMB TO MS. BETTY JAMES, APRIL 25, 1989

EXECUTIVE OFFICE OF THE PRESIDENT
Office of Management and Budget
Washington, D.C. 20503

Apr 25 1989

Ms. Betty James
Acting Assistant Secretary
for Management and Budget
Department of Health
and Human Services
Washington, D.C. 20201

Dear Ms. James:

The law firm of Myerson Kuhn and Sterrett has brought to my attention a reporting requirement in Section 4105.5 of the Medicare Carriers Manual requiring that ". . . suppliers with branch offices located in more than one carrier's jurisdiction identify on the Claim Form Number 1500 the address of the branch office actually supplying the service to the beneficiary." According to the Manual, the information to be supplied should be provided in block 24B of the HCFA-1500 form, which is currently approved under OMB No. 0938-0008. Myerson Kuhn and Sterrett has requested our view as to whether the Manual provision is subject to the Paperwork Reduction Act (PRA) of 1980 and, if so, whether it has been approved by this Office pursuant to the Act.

I regret to inform you that after carefully examining all available documentation of the Office of Management and Budget (OMB) clearance actions, we have determined that, on the face of the record, OMB cannot establish that the reporting requirement

in the Manual was ever submitted to OMB for PRA approval or that it received an OMB approval number under the Act. The OMB public docket contains no evidence of prior agency submission and OMB approval of this requirement. It is my understanding, however, that HCFA staff recollect that the Manual was submitted with the form at one time, and that they would sign an affidavit to that effect.

Additionally, I would like to make you aware that, if a contractor imposes a requirement for information from the public that is not required on the HCFA-1500 or other approved collections subject to the PRA, the public protection clause of the Act (section 3512) applies. Your contractors should therefore be reminded that if they impose requirements that substantially amend the HCFA-1500 or other approved collections, such requirements are not enforceable under the public protection provision unless approved pursuant to the Act.

Lastly, while evaluating our information collection review procedures for the Carriers Manual, we discussed the possibility of reviewing Intermediary and Carriers Manual revisions pursuant to Executive Order No. 12291 (E.O. 12291): We believe these guidance revisions implementing administrative policy are of significant importance in the context of statutory and regulatory priorities and are therefore subject to our review under E.O. 12291. We are interested in your views on how this review should proceed.

Thank you for your cooperation on these issues. If your staff have any questions or concerns, your staff should contact Allison Herron at 395-7316.

Appendix E

Sincerely,

Jay Plager
Administrator
Office of Information
and Regulatory Affairs

Enclosures

APPENDIX E — EXHIBIT III—J. PLAGER OMB TO MR. JOHN COONEY, APRIL 26, 1989

EXECUTIVE OFFICE OF THE PRESIDENT
Office of Management and Budget
Washington, D.C. 20503

April 25, 1989

Mr. John F. Cooney, Esquire
Myerson Kuhn & Sterrett
1330 Connecticut Avenue, N.W.
Washington, D.C. 20036

Dear Mr. Cooney:

Thank you for your letter dated January 18, 1989 regarding a reporting requirement in Section 4105.5 of the Medicare Carriers Manual requiring that ". . . suppliers with branch offices located in more than one carrier's jurisdiction identify on the Claim Form Number 1500 the address of the branch office actually supplying the service to the beneficiary." According to the Manual, the requested information should be provided in block 24B of the HCFA-1500 form (0938-0008). You have requested our view as to whether the Manual provision is subject to the Paperwork Reduction Act (PRA) of 1980 and, if so, whether it has been approved by this Office pursuant to the Act.

After carefully examining all available documentation of the Office of Management and Budget (OMB) clearance actions, we have determined that, on the face of the record, OMB cannot establish that this reporting requirement in the Manual was ever submitted for PRA approval or that it received an OMB approval number under the Act. The OMB public docket contains no evidence of prior agency submission and OMB approval of this

requirement. It is my understanding, however, that HCFA staff recollect that the Manual was submitted with the form at one time, and that they would sign an affidavit to that effect.

While the Form 1500 has been approved, the requirement in the Manual is not on the form, nor is the requirement directed to respondents, made readily available to respondents or identified as instructions to respondents. The Carriers Manual containing this provision does not display an OMB approval number, and past *Federal Register* notices informing the public of opportunity for comment have referred only to the form and not to the Manual. I have attached our recent correspondence to the Department conveying these facts.

Issues involving PRA violations are of extreme importance to us, and I thank you for bringing this matter to our attention.

Sincerely,

Jay Plager
Administrator
Office of Information
and Regulatory Affairs

Enclosure

APPENDIX F — EXCERPTS FROM PROSECUTION'S APPELLATE BRIEF

UNITED STATES COURT OF APPEALS

FOR THE SECOND CIRCUIT

Docket Nos. 89-1434
89-1445

UNITED STATES OF AMERICA,

Appellee

-against-

STEVEN B. WEISS, BARRY GLEICHER, PATIENT MEDICAL SYSTEMS, CORP. a/k/a "INTEGRATED GENERICS, INC." and HEALTH-MED, INC.,

Defendants,

PATIENT MEDICAL SYSTEMS, CORP., a/k/a "INTEGRATED GENERICS, INC.", BARRY GLEICHER,

Defendants-Appellants.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF NEW YORK

BRIEF FOR THE APPELLEE

PRELIMINARY STATEMENT

Patient Medical Systems, Corp., a/k/a Integrated Generics,

Inc., ("PMS") and Barry Gleicher appeal from judgments entered on August 21, 1989 after a jury trial in the United States District Court for the Eastern District of New York (Wexler, J.).[1] The jury convicted the defendants of a mail fraud conspiracy, in violation of 18 U.S.C. Sec. 571. The jury found Gleicher guilty of five counts of mail fraud and PMS guilty of three counts of mail fraud, in violation of 18 U.S.C. Sec. 1341. They also found Gleicher guilty of nine counts and PMS guilty of six counts of making false representations of material facts on Medicare claims in violation of 42 U.S.C. Sec. 1395 nn (a)(1). Finally, the jury found Gleicher and PMS guilty of three counts of making false representations of material facts on Medicaid claims in contravention of 42 U.S.C. Sec. 1396 (h)(a)(1).

On August 21, 1989 Judge Wexler sentenced PMS and Gleicher. Gleicher received a three-year term of incarceration and a $1,000 fine on the conspiracy count. He also received concurrent sentences of three-years incarceration and consecutive $1,000 fines on each of the five mail fraud counts. For each of the fraudulent Medicare and Medicaid counts Gleicher received a concurrent sentence of five years probation to run consecutive to his three-year prison term and consecutive fines of $10,000. A court assessment fee of $50 was also imposed on each count. In sum, Gleicher was sentenced to a three-year term of imprisonment, to be followed by a five-year term of probation, and to total fines and court assessments of $126,900.00.

PMS was sentenced on the conspiracy count to pay a $10,000 fine. On each of the three mail fraud counts, PMS was fined $1,000. On each of the three Medicare counts, PMS was fined

---

1. Steven B. Weiss has not yet been sentenced. Health Med Inc. ("Health Med") has not appealed its conviction.

$12,500, and each of the three Medicaid counts, PMS was fined $25,000. PMS was also ordered to pay $10,000 for the cost of the prosecution and a court assessment of $50 on each count. The total of the fine, including the cost of the prosecution and court assessment, was $173,650.00. The fine was payable in 90 days.

Judge Wexler stayed Gleicher's sentence pending the appeal. The government has elected to forego enforcement of the fine portion of the judgment against PMS until the argument of the appeal.

On appeal, Gleicher and PMS raise six points. First, Gleicher, with PMS joining in, claim that their convictions should be reversed because the Medicare Carriers Manual proscribing their fraudulent conduct was not properly approved under the Paperwork Reduction Act. Second, Gleicher, again with PMS joining in, claims that their conduct was not expressly prohibited by any sections of the Medicare Carriers Manual. Third, Gleicher seeks reversal of five counts because they relate to a time when he was not formally connected with PMS or Weiss. Fourth, PMS claims that the prosecutor's cross-examinations and summation were unfair. Fifth, PMS contends that the district court unfairly applied Rule 16, F.R.Crim. Pro., to prohibit the defense from admitting impeachment documents it had not disclosed to the government while permitting the government to admit for impeachment and direct evidence documents they had similarly not disclosed. Finally, PMS claims that the magistrate's selection of the jury with their express consent violates the subsequent Supreme Court decision of *United States v. Gomez,* 109 S. Ct. 2237 (1989).

As will be shown below, all of these arguments lack merit.

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* * *

to January of 1986. After Health Med Inc. allegedly became defunct, PMS hired all of the Health Med employees, took over their customers, and continued the prior billing practices of Health Med (T 1258, 1306).

Gleicher was not an employee, officer or director of Health Med (T 780); but he was a vice president and treasurer of PMS (T 1852-53). Weiss was a vice president of PMS and president of Health Med Inc. Both Weiss and Gleicher met for the first time in August of 1983, had a number of conversations about billing Medicare and discussed the billing of Medicare claims to the government by computer (T 1260, 1306, 1421, 1422-4 and 1428). Weiss and Gleicher consulted on Medicare billings from 1983 through 1986.

2. Medicare Carriers Manual and the HCFA 1500 Claim Form

The local Medicare carriers contract with the government to receive, analyze and pay Medicare claims on behalf of the Department of Health & Human Services (HHS) (T 881). There are 47 Medicare carriers in the United States, which have specific geographic areas in which they are responsible for paying claims (T 882).

Official Medicare policy decisions are promulgated by the Health Care Financing Administration (the "HCFA") and are contained in the Medicare Carriers Manual, which is the official explanation of the statute and the regulations of the Medicare program. This is done pursuant to the general authority of the

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Secretary of the Department of Health and Human Services (T 883). The Manual gives the carriers specific instructions regarding the analysis, processing and payment of claims (T 883). These billing instructions are published in the Manual and are also published privately by CCH (T 882, 892). From time to time, the Medicare carriers summarize various sections of the Manual and send them to Medicare providers so that they may know what is properly reimbursable. The suppliers must follow the billing instructions in the Manual (T 955).

Relevant sections of this Manual addressing the jurisdiction of claims were admitted into evidence (T 884-5). The concept of jurisdiction governs which carriers are responsible for processing and paying claims from a particular supplier of durable medical equipment. The Manual section referring to seat lift chairs sets forth the eligibility of such claims for reimbursement (T 885).

The Medicare billing form, called the HCFA 1500, is discussed in the Manual. The defendants used the New Jersey edition of the HCFA 1500 Form in submitting their claims to the out-of-state carriers (T 888). On the reverse side of the HCFA 1500 are printed notices, which require an acknowledgment certifying the accuracy of the information on the form and which give notice that false statements or concealment of material facts may subject the provider to prosecution (T 370-1, 899).

The term point of sale is the site where the Medicare supplier meets with the Medicare beneficiary or receives their call. It is a phrase which is widely used and commonly accepted in the health care industry (T 889-90). The concept of "point of sale" determines which carrier has jurisdiction to pay and process claims and is contained in Section 3102.B of the Manual, although the phrase "point of sale" does not appear in the Manual.

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Under Section 4011.8 of the Manual, a Medicare supplier that has more than one office address must place the address for the branch office covering the point of sale in Box 31 (T 900, 942). This particular address determines jurisdiction.

* * * *

ARGUMENT

POINT ONE

THE DEFENDANTS CONVICTIONS DO NOT VIOLATE ANY PROVISIONS OF THE PAPERWORK REDUCTION ACT

In essence, PMS and Gleicher were convicted of fraudulently submitting Medicare claims to inappropriate local carriers and misrepresenting the point of sale on block 31 of HCFA 1500 form, so that they would be reimbursed a higher amount for seat lift chairs they sold to medicare beneficiaries. Gleicher, with PMS joining in his argument, claims that their convictions are invalid under the Paperwork Reduction Act (the "PRA") because that Act requires that all forms used by government agencies be approved by the Office of Management and Budget ("OMB"), and bear an OMB control number. If they do not, PMS continues, a person cannot be prosecuted for any crimes connected with filling out that form. In this case, although Gleicher concedes that the HCFA 1500 form received appropriate OMB approval and carries an OMB control number, he claims that his conviction is invalid because the Medicare Carriers Manual, which provides the only explanation of the point of sale for purpose of submitting and processing claims and completing block 31 of 1500 HCFA form, did not.

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Gleicher's analysis is based upon a distorted interpretation of the Act, OMB regulations under it, form 1500 and the Manual. When these distortions are cleared up, as Judge Wexler correctly found, only the form and not the Manual needed OMB approval. Thus, PMS and Gleicher's convictions may stand.

A. The Medicare Carriers Manual is Not an "Information Collection Request" Within the Meaning of the Paperwork Reduction Act

To understand Gleicher's argument that the Manual lacked sufficient approval, it is necessary to review the PRA and the legislation and reimbursement system underlying the seat lift chair program.

1. The Paperwork Reduction Act

The aim of the PRA is to eliminate unnecessary "collections of information." As stated in the Act, it was passed by Congress to "minimize the Federal paperwork burden for individuals, small businesses, State and local governments, and other persons" and to "ensure that automatic data processing, telecommunications, and other information technologies are acquired and used by the Federal Government in a manner which improves service delivery and program management, increases productivity, improves the quality of decision making [and] reduces waste and fraud . . . . " 44 U.S.C. Sec. 3501.

Thus, in the Act Congress established the office of Information and Regulatory Affairs within OMB, 44 U.S.C. Sec. 3501 (a), and required its administrator to "review[] and approv[e] information collection requests proposed by agencies [, and to] determin[e] whether the collection of information by an agency

is necessary for the proper performance of the functions of the agency". *Id.* Sec. 3504 (c) (1), (2). OMB approved information collection requests carry a "control number". 44 U.S.C. Sec. 3504 (c) (3) (A).

The term "information collection request" is defined as:

> a written report form, application form, schedule, questionnaire, reporting or recordkeeping requirement, collection of information requirement, or other similar method calling for the collection of information.

44 U.S.C. Sec. 3502(11).

The legislative history further clarifies its meaning:

> The term "information collection request" refers to the *actual* instrument used for a collection of information. It is the information collection request which must be submitted to the Director in accordance with the clearance requirements of section 3507.

S. Rep. No. 930, 96th Cong., 2d Sess. 39, *reprinted in* 1980 U.S. Code Cong. & Ad. News 6279 (emphasis added).

2. The Seat Lift Chair Program and Reimbursement System

Title XVIII of the Social Security Act, 42 U.S.C. Sec. 1395 *et seq.*, established the Health Insurance for the Aged and Disabled Program, popularly known as Medicare. The Secretary of the

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Department of Health and Human Services is responsible for administering the Medicare program and has been granted general rulemaking authority in order to fulfill that responsibility. 42 U.S.C. Sec. § 1395kk, 1395hh.

The seat lift chair program falls under Medicare Part B, a voluntary subscription program of supplementary medical insurance covering, in general, 80% of the reasonable charges for certain other services such as laboratory tests, x-rays and ambulance services. 42 U.S.C. § § 1395j-1395w. Benefits under Part B are financed by appropriations from the Treasury and by premiums paid by those who choose to enroll in the Part B program. 42 U.S.C. Secs. 1395j, 1395r, 1395s and 1395w.

The only point of contention is whether the Manual is governed by the PRA. It is not, because under the PRA, OMB's authority extends only to clearance of an "information collection request," and the Manual does not constitute one.

The Manual is not an information collection request under any category of Section 3052(11). It is certainly not a "written report form" nor an "application form." It could not be a "schedule" or "questionnaire." Neither is it a "reporting or recordkeeping requirement" because it imposes no burden upon a Medicare Part B supplier to keep records of information that is not submitted to HCFA on the HCFA 1500 form.

Finally it is not a "collection of information requirement or other similar requirement for the collection of information." Such requirement is defined as:

> obtaining or soliciting of facts or opinions by an agency through the use of written report forms,

> application forms, schedules, questionnaires, reporting or recordkeeping requirements or other similar methods calling for either-
>
> (A) answers to identical questions posed to, or identical reporting or recordkeeping requirements imposed on, ten or more persons . . . .

Sec. 3502 (4) (A). Rather than collecting information, the point of sale instruction gives information — it directs the supplier to submit its claims to certain carriers and instructs the carriers which claims they are to process.

Nor is Gleicher's position supported by the legislative history, despite his claim to the contrary (Gleicher Brief at 23). In enacting the PRA, Congress made clear that:

> Section 3518 (a) states that, except as otherwise provided in this chapter, the authority of an agency under any other law to prescribe policies, rules, regulations, and procedures for federal information activities is subject to the authority conferred on the Director by this Chapter. An example of such an agency prescription would be the *actual means, instruments or forms used for the collection of information.*

Senate Report at 5 U.S. Code Cong. & Ad. News at 6295 (emphasis added). The HCFA 1500 form, not the Manual, is the "actual means, instruments or forms used for the collection of information."

Equally unavailing is Gleicher's extensive quote from

comments made in June 1988 by a senator who was a sponsor of the bill which became the PRA. Gleicer Brief at 13-14, quoting Senator Lawton Chiles. Comments made by a legislator eight years after enactment of a statute should be afforded little weight in interpreting congressional purpose. *Citizens State Bank of Marshfield, Mo. v. F.D.I.C.*, 751 F.2d 209 (8th Cir. 1984); *National Labor Relations Board v. Res-Care, Inc.*, 705 F.2d 1461 (7th Cir. 1983).

In addition, the senator's comments simply do not support Gleicher's point. Senator Chiles stated:

> The fundamental premise of the Paperwork Reduction Act is that every person, be they a business or State or local government, university or individual citizen, is entitled to an assurance that their government has checked for needs and efficacy before they are asked to provide or maintain information. That is what the public protection section of the Act is all about. I think it is the guts of the Act. That is what the display of control numbers of forms and regulations is designed to indicate, that the government has checked. If the paperwork request does not display that control number, then we say it is a bootleg request, it is in violation of the assurance that the Paperwork Reduction Act was intended to provide all citizens, and it is legally unenforceable.

S. Hrg. 100-706, Confirmation Hearings of S. Jay Plager before the Senate Committee on Governmental Affairs, June 14, 1988, P. 10.

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B. A Ninth Circuit Case Does Not State Otherwise

Gleicher is wrong to argue that *United States v. Smith* 866 F.2d 1092 (9th Cir. 1989), rejects the government's position (Gleicher's Brief at 19). Even were a Ninth Circuit case controlling, *Smith* is inapposite.

In that case, independent miners refused to file a plan of operations regarding their activities in a national forest, as required by the United States Forest Service. They were convicted of failure to file the plan. The Court, relying on section 3512, reversed the convictions because the "information collection request" in question did not carry an OMB control number.

The instant case is very different. First, Gleicher and the other defendants were not prosecuted for refusing to fill out a form or file a plan. Instead, they affirmatively committed a fraud by misrepresenting the point of sale and intentionally submitting the claims to the wrong carrier. He thus, through an affirmative misrepresentation rather than an omission, created the appearance of doing business through local sales offices, which the jury decided were wholly ephemeral.

Second, *Smith* does not support Gleicher's argument that the Manual is in itself, an "information collection request." In *Smith*, the defendant mine operators were convicted of failing to file the plan. The court found that this Park Service request constituted an "information collection request" pursuant to the PRA. 44 U.S.C. § 3502(11). It also found that the plan request did not carry an OMB control number. However, the plan could be, but was not required to be, submitted on a certain form known as an Alaska Placer Mining Application. The plan could also be submitted as a narrative, at the option of the mine operator. OMB

had cleared neither this narrative submission nor the application form.

In the instant case, the HCFA 1500 *did* carry an OMB control number. And the HCFA 1500 was *not* optional, as was the Alaska Placer Mining Application in the *Smith* case, but was required to be submitted by Medicare Part B providers seeking reimbursement. A narrative was not acceptable to HCFA. Thus, in the instant case the "*actual*" instrument used to collect information was by necessity the HCFA 1500 form. Thus, the narrative plan in *Smith* bears no analogy to the Carriers Manual in the case at bar.

C. The PRA Regulations and OMB Comments Do not Support Gleicher's Argument

Gleicher also misplaces his reliance upon the regulations promulgated by OMB under the PRA. He apparently argues that OMB's own regulations defining "collection of information" somehow broaden the statutory definition of that term to include the Manual. Of course, it is doubtful that an agency can expand its authority by promulgating regulations which redefine a statutory term.

Even were that possible, the regulation in question simply does not cover an explanatory guide like the Manual. The regulation provides:

> A "collection of information" includes the uses of written report forms, application forms, schedules, questionnaires, reporting or recordkeeping requirements, or other similar methods. Similar methods may include contracts,

> agreements, policy statements, plans, rules or regulations, planning requirements, circulars, directives, instructions, bulletins, requests for proposal or other procurement requirements, interview guides, disclosure requirements, labeling requirements, telegraphic or telephonic reqests/ and standard qestionnaires used to monitor compliance with agency requirements.

5 CFR Sec. 1320.7(c)(1) (1986).

The Manual is none of these. Gleicher simply persists in arguing that many things other than "forms" can be "information collection requests." Although true, that is beside the point here. The government agrees that more than "forms" can contain "information collection requests." In this case, however, the false information was provided by defendants on a required form, which form and not the Manual is the "information collection request."

Gleicher also urges that OMB comments associated with the promulgation of regulations under the PRA support the conclusion that the Manual is an "information collection request." However, Gleicher's artful editing and use of ellipses distort the meaning of OMB's comments. The entire comment, with underlined material indicating what Gleicher omitted (Gleicer Brief at 19) is as follows:

> It is not possible to argue that OMB clearance authority is confined to forms and similar instruments. The key terms defining jurisdiction of the PRA —"collection of information" and "information collection requests" — are both defined expressly to include "reporting and

> recordkeeping requirements" in addition to "written report forms" and "application forms." 44 U.S.C. Section 3502(4), (11). Many reporting requirements are imposed by other means, including oral surveys [*guidelines, directives, and most significantly — regulations.*] *** OMB's intent [is] that the regulation cover information collection activities conducted through circulars, directives, instructions, bulletins, and standard questionnaires used to monitor compliance with agency requirements.

48 *Fed. Reg.* 13666, 13667, 13676 (March 31, 1983). The Manual does not fit any of the reporting requirements because it is not an oral survey, guideline, directive or regulation.

In addition, Gleicher also omits the heading and opening paragraph of this comment, which makes perfectly clear that OMB was addressing the question of whether it had authority under the PRA to review information collection requests promulgated by an agency through a rule or regulation adopted after public notice and comment:

> (a) *OMB authority to review reporting and record keeping requirements in current rules adopted after public notice and comment.*
>
> Several agencies and members of the public have commented that OMB'S authority to review collections of information does not extend to collection of information requirements contained in agency regulations, and the provisions of this rule implementing OMB authority over such

> requirements is inconsistent with a memorandum by the Office of Legal Counsel of the Department of Justice, dated June 22, 1982. These comments are based upon a misunderstanding of the Act and of the OLC memorandum.

48 Fed. Reg. 136667 (March 31, 1983).

The Manual is not a notice and comment rule or regulation. The author of Gleicher's Brief knows perfectly well that OMB was addressing notice and comment rules and regulations since he co-authored the OMB legal opinion to the Department of Justice regarding OMB powers over notice and comment rules and regulations. 24 Harvard Journal on Legislation (1987) 39-40, footnotes. Moreover, the United States Department of Justice Office of Legal Counsel Opinion of June 22, 1982[3] referenced in these comments (48 *Fed. Reg.* at 13667) was written *to* the author of the Gleicher Brief.

Moreover, the last sentence of the OMB comments as quoted in the Gleicher Brief at page 19, is excerpted from another section of the comments some ten pages later. It is misleading at best to create an amalgam of these comments on separate sections of the PRA. A reading of the entire section in which this last sentence appears does not weaken the government's position that where a form has been approved under the PRA and where the relevant information is submitted to the agency on that form that form is the only "information collection" request within the meaning of the PRA.

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3. Misdated in the Harvard Journal on Legislation as June 22, 1985. p.39-40, ftnt. 234. Compare with correct date in text of same article. p.49.

In addition, the reporting requirement is "*enforced*" by means of HCFA 1500 form, and not through the Manual. Therefore, the comments to the regulations are of no more help to Gleicher than were both the regulations and the statutory language. As discussed above, Congress defined an "information collection request"as "a written report form, application form, schedule, questionnaire, reporting or record-keeping requirement, collection of information requirement, or other similar method calling for the collection of information" 44 U.S.C. § 3502(11).

The HCFA 1500 is an application form. Congressional intent in naming other categories of "information collection requests" is to include reporting and record-keeping requirements not submitted through forms. For example, an agency might require employers to keep records of hazardous wastes in the workplace and make them available to the workers or the general public. In this instance, the government mandated recordkeeping would not be submitted to any government agency; nevertheless, it would be covered by the PRA.

Moreover, Gleicher's interpretation of the meaning of section 3502(11) "reporting or record-keeping requirements" would make the term "application form" superflous. The information collected, the point of sale, is required to complete the form and for no other purpose. There is no requirement that it be made available to workers or to the general public or to any other party, only that it be submitted on the HCFA 1500.

Finally, Gleicher's interpretation, carried to its logical conclusion, would create confusion and vitiate other acts of Congress. It would mean that anyone who does not wish to fill out a form approved by OMB and carrying a control number could go behind the form and question the entire reimbursement

structure for a government program, claiming that it is a new and separate "information collection request," just as Gleicher does. However this was not the intent of Congress in enacting the PRA.

D. The Plager Letter Does Not Represent the Legal Opinion of the United States

Gleicher next urges that a legal opinion rendered in 1989, on the very eve of trial, by Jay Plager, Administrator of the Office of Information and Regulatory Affairs of OMB, is binding on the United States and this Court.[4] Gleicher presented that opinion to Judge Wexler just before trial and moved on the basis of it for dismissal of the case. For several reasons, Judge Wexler correctly denied the motion.

First, PMS and Gleicher were prosecuted by the United States, not OMB or HCFA. The Department of Justice, not some agency official, represents the United States before the courts. 28 U.S.C. § 516 provides:

> Except as otherwise authorized by law, the conduct of litigation in which the United States, an agency, or officer thereof is a party/ or is interested/ and securing evidence thereof, is reserved to the officers of the Department of Justice, under the direction of the Attorney General.

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4. Gleicher's reference to testimony of the government expert purporting to reject Plager's opinion, Gleicher Brief at 21, is to no avail. Gleicher mixes law and fact. The question of whether the Manual is an information collection request pursuant to the PRA is a question of law and interpretation of the PRA, and not a subject of "expert" testimony to be presented to the jury.

25 U.S.C. § 516. In this case, the Administrator, Office of Information and Regulatory Affairs, is not otherwise authorized, *i.e.* he has no statutory or other authority to render legal opinions which are binding on this court or in the United States, including having no statutory or other authority to render legal opinions about even the administrative law aspects of a criminal proceeding. Certainly, then he has no authority to render a legal opinion regarding the legal sufficiency of an indictment properly handed up by a grand jury.

Second, even if Plager had the authority, his letter would present a dispute between OMB and the Department of Justice. If two federal agencies disagree over a question of law, that question is decided by the Department of Justice. 25 Op. Atty. Gen. 301 (1904). This long standing federal policy was reaffirmed in Executive Order No. 12146:

> *Resolution of Interagency Legal Disputes*
>
> Whenever two or more Executive agencies are unable to resolve a legal dispute between them, including the question of which has jurisdiction to administer a particular program or to regulate a particular activity, each agency is encouraged to submit the dispute to the Attorney General.
>
> Whenever two or more Executive agencies whose heads serve at the pleasure of the President are unable to resolve such a legal dispute to the Attorney General prior to proceeding in any court, except where there is specific statutory vesting of responsibility for a resolution elsewhere.

Appendix F

Executive Order No. 12146 (July 18, 1979, 44 F.R. 42657, as amended by Ex. Order No. 12608, September 9, 1987, 52 F.R. 34617). Thus, Plager is not in a position to decide the dispute through his letter.

Third, the letter was not subject to sufficient scrutiny. Gleicher presented it on the eve of trial as part of a motion to dismiss on purely legal grounds, which motion Judge Wexler ruled upon immediately and without requiring the government to contest factual matters therein. At trial the government also did not contest factual matters, since Gleicher did not make the letter a factual issue for the jury. Accordingly, the trial court was not given the opportunity to test the authoritativeness of this letter purporting to cover OMB policy up to eight-years earlier. Without the benefit of the trial court's views, this Court should not rely upon this letter.[5]

* * *

In sum, PMS and Gleicher were convicted of intentionally perpetuating a fraud by misrepresentations they repeatedly made on form 1500 and intentionally submitted to the wrong carrier. Their convictions do not violate the PRA because they committed their fraud in part using a form properly approved by OMB. This conclusion is in no way undermined by the Ninth Circuit case of *Smith*, regulations and OMB comments about the PRA or a letter by Jay Plager.

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5. Were it appropriate, the government would contest the authoritativeness of the letter. However, because prior OMB documents which cast doubt on the legal conclusions in it were not part of the trial record, the Court correctly struck from the government's appendix earlier OMB documents which might have provided a fuller review of the letter.

Appendix F

Moreover, Gleicher's arguments about the scope of the PRA are curious because even if they were completely successful and even if the HCFA form 1500 bore no OMB approval which we have shown is certainly not the case, Gleicher and PMS could still be prosecuted for intentionally filing false information on a form not carrying an OMB number. Gleicher alleged shelter from the consequences of the defendants' crimes is the Public Protection provision of the PRA. That provides:

> [N]o person shall be subject to any penalty for *failing to maintain or provide information* to any agency if the information collection request . . . does not display a current control number assigned by the Director, or fails to state that such request is not subject to this chapter.

Id. Sec. 3512 (emphasis added). As a commentator recently stated, laying Gleicher's argument to rest: "The Public Protection Provision at most only protects a person from penalties for *failing to file information*. It does not protect one who *files information which is false.*" 24 Harvard Journal on Legislature, (1987), p. 77 Fn 411 (emphasis supplied).

In this case, of course, Gleicher and PMS falsely completed the form and wrongly submitted it to obtain larger reimbursements for the seat lift chairs they supplied. They hide behind the policy underlying the PRA, by claiming that the paperwork underlying the seat lift chair reimbursement procedures is an example of papers "out of control," imposing a $100 billion dollars in "hidden taxes" upon the population. Gleicer Brief 4. The defendants ask this Court to forget they added to their paperwork by setting up sham paper transactions such as bulk mailing of completed HCFA 1500 forms to a supposed "local office" where they individually

remailed the forms to the local Medicare carrier, in an attempt to cause the carrier to believe that with the local postmark and a local address for the defendants on the claim form the point of sale was within the carrier's jurisdiction. Thus, the postmark indicated that, rather than New York, the true point of sale was local. Defendants are like a merchant who keeps two sets of books to defraud the tax collector and then complains of the extra paperwork burden of double bookkeeping. It was the defendants themselves, who created their own paperwork burden. Thus, the defendants' invocation of a statute intended by Congress to reduce government required paperwork is audacious.

* * *

Weiss quoted verbatim a portion of Section 4105.5 to the Ohio carrier investigator, of course further demonstrated his knowledge of the contents of the Manual (T 523-26).

In short, this and the other trial evidence demonstrate criminal intent on the defendants part and their misuse of the office address and telephone numbers to circumvent the mandates of the point of sale rule and the Medicare billing instruction.

B. The Duty to Provide Point of Sale Information on the Medicare Claim Form Does Not Arise Solely From Medicare Carrier's Manual Section 4105.5

Although it is true that point of sale information required on block 31 of form 1500 is not mentioned in Manual Section 4105.5, that is not dispositive, as indicated directly above, Section 4011.8 requires the name and address and phone information. As also indicated above, the CCH Medicare and Medicaid Guidebook at paragraph 10,275.08 had a heading which indicates

that this address information is placed in Box 31 of the HCFA 1500 form. Again, this section states that the information is necessary as an aid in determining jurisdiction of the claims. Defendant's misrepresentation as to its branch location on the Medicare forms is a material misrepresentation of facts which prevented the carriers from determining whether they had the requisite jurisdiction to pay the defendants' claims.

* * *

APPENDIX G — EXCERPTS FROM GOVERNMENT'S BRIEF IN *MELASHENKO v. BOWEN*, NO. CIV. F-87-533 5 CCH MEDICARE/MEDICAID GUIDEBOOK¶38,827 (E.D. CAL. 1989)

Moreover, nowhere in the legislative history of section 1128(b)(6)(B) does Congress discuss or include a requirement that a practitioner must be accorded an educational contact or the change to correct prior to exclusion. Nor does Congress suggest that an exclusion can only be used as a last resort, after a pattern of objectionable conduct has been found.[42] In short, Congress has in no way endorsed, either expressly or impliedly, the additional requirements which plaintiff wishes to engraft upon the Medicare practitioner sanction process, either under section 1156 or under section 1128(b)(6)(B). Thus, plaintiff's tortured attempt to use Congressional intent in support of his specious claims must be rejected.

C. The Manuals Do Not Provide Plaintiff With Additional Substantive Rights

1. The Manuals Have No Legal Effect.

Enmeshed with his argument on Congressional intent, plaintiff discusses various provisions of the OHFI (now OIG)

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42. Congress did comment, with respect to section 1128(b)(6)(B), that if the violation is "isolated or inadvertent," it expected the Secretary to "insist on prompt corrective action" rather than excluding the practitioner. *Id.* As the voluminous documentation and medical opinions of *nine* physicians in this case showed, however, plaintiff's violations were neither inadvertent nor isolated. Exhibits 10, 11, 12, 14, and 15.

Moreover, as discussed below, plaintiff here was given education contacts by Dr. Woodley and did *not* correct his conduct; thus, the exclusion sanction against plaintiff was, indeed, used as a last resort.

manual and Medicare Carrier's manual. Plaintiff's Memo, at 3-6, 47-53. According to plaintiff, these various manual provisions provided him with a variety of rights which OIG and BCBSM did not accord to him in this case; among them, the right to an educational contact or warning, and the preclusion of any sanction until or unless he refused or failed to remedy a clear pattern of objectionable conduct. Plaintiff's Memo, at 4-5.

As an initial matter, the manuals to which plaintiff refers are not laws or regulations. They are merely *guidelines* which have no "legal force" and are not binding on the Secretary. *Schweiker v. Hanson,* 450 U.S. 785, 789 (1981); *Whaley v. Schweiker,* 663 F.2d 871, 873 (9th Cir. 1981); *Rosenfeld v. Secretary of Health and Human Services,* 563 F. Supp. 1192, 1194 (E.D.N.Y. 1983). Neither section 1862(d)(1)(C) (or the current section 1128(b)(6)(B)) nor regulations governing a section 1862 proceeding, require that practitioners be provided with persuasive and educational efforts or warning from the carrier before a sanction can be imposed. Moreover, section 1862(d)(1)(C) and its supporting regulations do not mandate that the practitioner must fail or refuse to correct a pattern of abusive conduct prior to sanction. As this Court found when plaintiff previously presented this argument with respect to one particular provision of the OHFI manual, "[t]he OHFI manual outlines the procedures which should 'generally' be followed. There is no reason to believe that the Secretary is *bound* to abide by the recommendations contained in the OHFI manual." Exhibit 26, *Order Re Request For Injunction Pending Appeal,* at 3 (emphasis in original).

This Court's determination should be no different now, despite plaintiff's addition of another manual (*i.e.,* the Carrier's Manual), which he describes as "external," to the discussion. Plaintiff's Memo, pp. 23-24, 48. For like the OHFI manual, the

Carrier's manual is an internal agency document which sets forth OIG's "internal house-keeping measures organizing Agency activities." *Guadamuz v. Bowen,* 859 F.2d 762, 771 (9th Cir. 1988), *quoting Zaharakis v. Heckler,* 744 F.2d 711, 713 (9th Cir. 1984). They present no more than "rules of agency organization, procedure [and] practice." *Powderly v. Schweiker,* 704 F.2d 1092, 1098 (9th Cir. 1983), *quoting* 5 U.S.C. § 553(b)(A) (*i.e.*, the Administrative Procedure Act (APA)). These manuals "merely clarify or explain existing law . . .[and] regulations, [citations omitted] are essentially hortatory and *instructional*, [citation omitted] and do not have the full force and effect of a substantive rule but [are] in the form of an explanation of particular terms." *American Hosp. Ass'n v. Bowen,* 834 F.2d 1037, 1045 (D.C. Cir. 1987) (holding the PRO manual and other PRO-related contracts and policy directives to be "mere procedural rules or general statements of policy that do not substantially alter the rights or interests of regulated hospitals").[43] Thus, like the PRO manuals, the manuals relied upon so heavily by plaintiff have no legal effect, and the fact that the Carrier's manual is distributed to government contractors (*i.e.*, the carriers) is of no legal consequence.

In making his argument, of course, plaintiff is in a difficult position. On the one hand, he asserts that certain changes in these manuals made after passage of section 1156 were "*mandatory* and *substantive*" (Plaintiff's Memo, pp. 48-49), even though procedural in nature (Plaintiff's Memo, at 5-6) and therefore,

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43. Moreover, like the PRO manual and other documents at issue in *American Hosp. Ass'n,* the manuals in the present case "do not . . . foreclose alternate courses of action or conclusively affect rights of private parties." *Id.* at 1045, *quoting Batterton v. Marshall,* 648 F.2d 694, 702 (D.C. Cir. 1980).

are binding on OIG in this case. (Plaintiff's Memo, pp. 49-51).[44] However, if the manual provisions are substantive rules, in order for them to be valid they must be published in the Federal Register to allow an opportunity for interested members of the public to comment. *See Powderly v. Schweiker,* 704 F.2d at 1097, citing the APA. *See also Chrysler Corp. v. Brown,* 441 U.S. 281, 303 (1979) ("the promulgation of [legislative or substantive] regulations must conform with any procedural requirements imposed by Congress", in order for them to have the force and effect of law). Thus, if this Court finds that the manual provisions discussed by plaintiff embody substantive rules, then it must strike them down as being violative of the APA. If the manual provisions are struck down, then plaintiff cannot successfully argue that they bind OIG.

In an order to avoid this result, therefore, Plaintiff asserts that even though these manual provisions are mandatory and substantive, there was no need for the Secretary to comply with the notice and comment procedures of the Administrative Procedure Act (APA), because these provisions fit within the "benefits" exception provided in 5 U.S.C. § 553(a)(2), and thus, APA compliance was unnecessary. (Plaintiff's Memo, pp. 50-51).

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44. Plaintiff cites only one case in which a court accorded procedural requirements in an internal manual the force and effect of law; *i.e., Cubanski v. Heckler,* 781 F.2d 1421 (9th Cir. 1986), *rehearing en banc denied,* 794 F.2d 540 (9th Cir. 1986), *judgment vacated, Bowen v. Kizer,* 481 U.S. 1012 (1988). Plaintiff's Memo, at 5-6.

Significantly, in vacating a judgment, the Supreme Court "eliminates a judgment, review of which was prevented through happenstance." *United States v. Munsingwear, Inc.,* 340 U.S. 36, 40 (1950). Thus, the *Cubanski* decision is a nullity, and plaintiff, therefore, has cited no authority to support his assertion.

Plaintiff, however, is apparently unaware that the Secretary *waived* any possible applicability of the APA benefits exemption to substantive rules under Medicare in 1971, when the Department voluntarily agreed to comply with the notice and comment requirements of the APA in promulgating substantive rules under the Medicare Act. *See* 36 Fed. Reg. 2532 (February 5, 1971).

The bottom line, of course, is that the "legislative" or substantive regulations in this case are those contained at 42 C.F.R. §§ 1001.1 *et seq.*, for those are the regulations issued by the Secretary (*i.e.*, the agency) pursuant to the statute, which implement section 1862(d) (the current section 1128(b)(6)(B)). *Chrysler Corp. v. Brown,* 441 U.S. at 302-303. The manual provisions to which plaintiff refers did not change existing law (i.e., section 1862(d) and 42 C.F.R. § 1001.105) or policy, and did not "remove previously existing rights" of practitioners. *Guadamuz v. Bowen,* 859 F.2d at 771.

2. The Manuals Were Properly Followed in This Case.

OIG's proposed exclusion letter of October 31, 1986, and its final exclusion letter of August 31, 1987, make clear that the statutory authority for plaintiff's exclusion is section 1862(d)(1)(C) (the current section 1128(b)(6)(B)) of the Act. Exhibits 19 and 21. Neither that statute, nor its implementing regulations (*i.e.*, 42 C.F.R. §§ 1001.1 *et seq.*) refer to any requirement that a practitioner be accorded persuasive or educational efforts prior to exclusion, or that the practices must consist of a pattern which the practitioner fails or refuses to remedy before a sanction may be levied.

Although plaintiff is mistaken in his reliance upon the

manuals,[45] a review of the record evidence reflects that, in fact, BCBSM undertook educational efforts, but plaintiff did not thereafter change his practices.

On December 6, 1983, BCBSM first identified the overuse of scopic procedures as a problem, indicating that in addition to the vast numbers of such procedures, the stated diagnoses and other medical documentation rendered "questionable" the medical necessity for performing the procedures. Exhibit 3, at 2. Other problems (which were billing in nature) were also noted, and the December 6, 1983 notice concluded with BCBSM's expressed expectation that the problems would be resolved by December 15, 1983. *Id.* at 3.

On January 20, 1984, BCBSM again wrote to plaintiff (and his partner), explaining in more detail the problem with overuse of scopic procedures. Exhibit 5. Mentioning endoscopic procedures (*i.e.*, colonoscopy, gastroscopy, and upper gastrointestinal endoscopy), the notice explained that a review of cases where these procedures were done showed that "the medical records did not support the medical necessity of the procedures." *Id.* Moreover, it was noted that "adequate workups were not done before the endoscopic procedures." *Id.*

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45. Such reliance ignores the manuals themselves, which specify that "educational or persuasive efforts are not necessary nor desirable when the issues involve life threatening or harmful care or practice." Section 11033.2A, Medicare Carrier's Manual; Section 5040A, OHFI Manual (*see* Plaintiff's Exhibits 10 and 11). In this case, as plaintiff was informed at the time of the proposed sanction on October 31, 1986 (Exhibits 11 and 19), at least two of the patients whose care formed the basis of the sanction were placed in imminent danger by that care.

Appendix G

The subject was again discussed in a telephone conversation between Dr. Woodley and plaintiff's partner, Dr. Thorbus, on January 24, 1984, when Dr. Woodley *again* indicated that the doctors were "over doing it according to present medical care standards." Exhibit 6, at 2-3.

On June 11, 1984, Dr. Woodley again wrote to plaintiff and his partner, noting that further review, including discussions with outside consultants such as gastroenterologists and proctologists, showed it was "clearly evident" that the doctors "have been grossly overutilizing" endoscopic procedures including upper gastrointestinal endoscopy and colonoscopy. Exhibit 7. Dr. Woodley noted the Mayo Clinic guidelines on the subject, and indicated that he had also reviewed guidelines proposed by several national societies of gastroenterology. He enclosed copies of pamphlet materials from gastroenterological societies with the letter to plaintiff. Dr. Woodley also addressed more specifically the problems encountered with the doctors' cases, and concluded with the stated hope that the doctors would resolve their overutilization and show more restraint in their use of endoscopic procedures. *Id.*

Despite these persuasive and educational efforts by BCBSM, plaintiff *did not* change his practices. Of the eleven cases upon which the sanction decision was based, *five* involved treatment of patients *after* January 1984 (*three* of the five received treatment between August and October 1984). Exhibit 21; Plaintiff's Exhibit 2, (ALJ Decision), at 51-105. Moreover, *both* of the patients whose care even the ALJ concluded was in violation of the statute, received the objectionable treatment *after* January 1984; one was treated by plaintiff in March 1984 and the other was treated by plaintiff in August 1984. Plaintiff's Exhibit 2, at 68-82, 97-100,

117, 120 (finding #11).[46]

Clearly, then, even though the manuals were not mandatory, they were followed in this case. Plaintiff received numerous educational contacts from Dr. Woodley, yet he continued performing unwarranted endoscopies which placed some of his patients in imminent danger. His pattern of poor quality care (which began in March 1983, according to the cases upon which the sanction was based) continued at least through October 1984, more than *ten months* after receiving the initial notice from BCBSM that a problem with his use of endoscopies existed. Thus, OIG was clearly justified in sanctioning plaintiff under section 1862(d)(1)(C), and both OIG and BCBSM followed the substance of the internal manuals, though perhaps not "to the last detail." *Schweiker v. Hanson*, 450 U.S. at 789-790.

D. Plaintiff is Not Entitled To Reinstatement at the Present Time

Plaintiff argues that he is entitled to "immediate reinstatement as a provider in the Medicare program." Plaintiff's Memo, at 39; *see generally*, Plaintiff's Memo, at 37-39 and 62-64. In his argument on this issue, he seeks to negate the significance of his filing of 24 claims during the period of his exclusion, arguing both that these added up to a relatively small amount [47] and that

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46. In view of this irrefutable evidence, it is unclear how plaintiff could credibly insist, as he does throughout his legal memorandum, that he "*immediately corrected his practice*" upon receipt of the first notice of problem on December 6, 1983. Plaintiff's Memo, at 7 (emphasis in original); *see also* Plaintiff's Memo, at 8, 10, 22, 25, 35, 60.

47. These claims totalled $1,656, of which $345.44 was erroneously paid to plaintiff by the Medicare carrier in California.

he had no knowledge of these improper claims, *i.e.*, that they were filed by "billing personnel" without his knowledge or permission, and thus he is not responsible for their filing.

1. This Court Has no Subject Matter Jurisdiction Over This Matter.

This court has no jurisdiction to overturn the Secretary's initial decision denying plaintiff's request for reinstatement. Exhibit 29. In enacting 42 U.S.C. § 1320a-7(g), which governs

* * *

APPENDIX G — PROSECUTOR'S AFFIRMATION IN OPPOSITION TO DEFENDANTS' MOTION FOR A JUDGMENT OF ACQUITTAL

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

CR # 88-0397 (LDW)

UNITED STATES OF AMERICA,

Plaintiff,

-v-

STEVEN B. WEISS, BARRY GLEICHER, PATIENT MEDICAL SYSTEMS, CORP., also known as INTEGRATED GENERICS, INC., and HEALTH-MED, INC.

Defendants.

AFFIRMATION

JON M. BEVILACQUA states and affirms under the penalties of perjury as follows:

1. I am a Special Assistant United States Attorney in the Office of Andrew J. Maloney, United States Attorney for the Eastern District of New York.

2. I am in charge of prosecuting the above-captioned indictment and as such I am fully familiar with the facts and circumstances concerning this prosecution.

3. This affirmation and accompanying memorandum of law

are submitted in opposition to the Defendants' Joint Motion for Judgment of Acquittal. The above-captioned indictment charges the defendants with the crimes of Conspiracy to Defraud the United States, Mail Fraud, and Making False Representations of Material Facts on Medicare and Medicaid claim forms. On May 18, 1989 the defendants were convicted of the aforesaid crimes.

4. Defense counsel at page 27 of their application to this Court maintain that the selection of the jury by a Magistrate constitutes plain error at this trial, relying on *Gomez v. United States,* U.S. Docket No. 88-5014 (June 12, 1989). In the *Gomez* case, the defense specifically objected to a Magistrate selecting the jury at trial. Defense counsel, at page 27 of their memorandum, state that, "In the case at bar, Magistrate Jordan presided over the jury selection. As there was no written waiver by the defendants of their right to an Article III Judge presiding at this critical state of a criminal trial, the proceedings must be deemed a nullity".

Prior to the selection of the trial jury, the Magistrate specifically asked each defense counel if they objected to his selection of the trial jury in this case. Each defense counsel then orally consented in the Magistrate's chambers to the Magistrate's selection of the jury in this case. Accordingly, since the defense consented to the Magistrate's selection of the jury in this particular matter, the selection of the jury by the Magistrate was proper and does not constitute "plain error".

5. The Government relies on the annexed Memorandum of Law in Opposition of the Defendants' Joint Motion for Judgment of Acquittal.

WHEREFORE, it is respectfully requested that this Court deny the defendants' requested relief in all respects.

Appendix H

JON M. BEVILACQUA
Special Assistant
United States Attorney

Dated: August 17, 1989
Hauppauge, New York

APPENDIX I — PROVISIONS INVOLVED

I. Statutes

Administrative Procedure Act

5 U.S.C. § 553

Rule Making

(a) This section applies, according to the provisions thereof, except to the extent that there is involved —

(1) a military or foreign affairs function of the United States; or

(2) a matter relating to agency management or personnel or to public property, loans, grants, benefits; or contracts.

(b) General notice of proposed rule making shall be published in the Federal Register, unless persons subject thereto are named and either personally served or otherwise have actual notice thereof in accordance with law. This notice shall include —

(1) a statement of the time, place, and nature of public rule making proceedings;

(2) reference to the legal authority under which the rule is proposed; and

(3) either the terms or substance of the proposed rule or a description of the subjects and issues involved.

Except when notice or hearing is required by statute, this

section does not apply —

(A) to interpretative rules, general statements of policy, or rules of agency organization, procedure, or practice; or

(B) when the agency for good cause find (and incorporates the finding and a brief statement of reasons therefor in the rules issues) that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest.

(c) After notice required by this section, the agency shall give interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments with or without opportunity for oral presentation. After consideration of the relevant matter presented, the agency shall incorporate in the rules adopted a concise general statement of their basis and purpose. When rules are required by statute to be made on the record after opportunity for an agency hearing, sections 556 and 557 of this title apply instead of this subsection.

(d) The required publication or service of a substantive rule shall be made not less than 30 days before its effective date, except —

(1) a substantive rule which grants or recognizes an exemption or relieves a restriction;

(2) interpretative rules and statements of policy; or

(3) as otherwise provided by the agency for good cause found and published with the rule.

(e) Each agency shall give an interested person the right to petition for the issuance, amendment, or repeal of a rule.

Paperwork Reduction Act

44 U.S.C. § 3507 (in pertinent part)

Public information collection activities — Submission to Director; approval and delegation

(a) An agency shall not conduct or sponsor the collection of information unless, in advance of the adoption or revision of the request for collection of such information —

(1) the agency has taken actions, including consultation with the Director to —

(A) eliminate, through the use of the Federal Information Locator System and other means, information collections which seek to obtain information available from another source within the Federal Government;

(B) reduce to the extent practicable and appropriate the burden on persons who will provide information to the agency; and

(C) formulate plans for tabulating the information in a manner which will enhance its usefulness to other agencies and to the public;

(2) the agency (A) has submitted to the Director the proposed information collection request, copies of pertinent regulations and other related materials as the Director may specify, and

an explanation of actions taken to carry out paragraph (1) of this subsection, and (B) has prepared a notice to be published in the Federal Register stating that the agency has made such a submission and setting forth a title for the information collection request, a brief description of the need for the information and its proposed use, a description of the likely respondents and proposed frequency of response to the information collection request, and an estimate of the burden that will result from the information collection request; and

(3) the Director has approved the proposed information collection request, or the period for review of information collection requests by the Director provided under subsection (b) has elapsed.

* * *

(f) An agency shall not engage in a collection of information without obtaining from the Director a control number to be displayed upon the information collection request.

* * *

44 U.S.C. § 3512

Public protection

Notwithstanding any other provision of law, no person shall be subject to any penalty for failing to maintain or provide information to any agency if the information collection request involved was made after December 31, 1981, and

does not display a current control number assigned by the Director, or fails to state that such request is not subject to this chapter.

Magistrate's Act

28 U.S.C. § 636 (in pertinent part)

Jurisdiction, powers and temporary assignment.

(a) Each United States magistrate serving under this chapter shall have within the territorial jurisdiction prescribed by his appointment—

* * *

(3) the power to conduct trials under section 3401, title 18, United States Code, in conformity with and subject to the limitations of that section.

(c) Notwithstanding any provision of law to the contrary—

(1) Upon the consent of the parties, a full-time United States magistrate or a part-time United States magistrate who serves as a full-time judicial officer may conduct any or all proceedings in a jury or nonjury civil matter and order the entry of judgment in the case, when specially designated to exercise such juridiction by the district court or courts he serves . . . .

(2) if a magistrate is designated to exercise civil jurisdiction under paragraph (1) of this subsection, the clerk of the court shall, at the time the action is filed, notify the parties

of their right to consent to the exercise of such jurisdiction. The decision of the parties shall be communicated to the clerk of court. Thereafter, neither the district judge nor the magistrate shall attempt to persuade or induce any party to consent to reference of any civil matter to a magistrate. Rules of court for the reference of civil matters to magistrates shall include procedures to protect the voluntariness of the parties' consent.

Criminal Code

18 U.S.C. § 3401 (in pertinent part)

Misdemeanors; application of probation laws.

(a) When specifically designated to exercise such jurisdiction by the district court or courts he serves, any United States magistrate shall have jurisdiction to try persons accused of, and sentence persons convicted of, misdemeanors committed within that judicial district.

(b) Any person charged with a misdemeanor may elect, however, to be tried before a judge of the district court for the district in which the offense was committed. The magistrate shall carefully explain to the defendant that he has a right to trial, judgment, and sentencing by a judge of the district court and that he may have a right to trial by jury before a district judge or magistrate. The magistrate shall not proceed to try the case unless the defendant, after such explanation, files a written consent to be tried before the magistrate that specifically waives trial, judgment, and sentencing by a judge of the district court.

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II. REGULATIONS

5 C.F.R.§ 1320.5 Public Protection.

(a) Notwithstanding any other provision of law, no person shall be subject to any penalty for failure to comply with any information collection request if the request does not display a currently valid OMB control number or, in the case of an information collection request which is submitted to nine or fewer persons, the request fails to state that for this reason it is not subject to OMB review under the Act.

III. *Medicare Carriers Manual Provisions*

§ 3102. AREA CARRIER - SUPPLIER'S SERVICES (in pertinent part)

* * *

b. *Suppliers with Branch Offices or Sales/Rental Outlets in More Than One Carrier Jurisdiction.*—Jurisdiction of payment requests for services of a supplier (see § 3102F if the supplier is an independent laboratory), with branch offices or sales/rental outlets in more than one carrier's jurisdiction lies with the carrier for the location where the service is furnished to the beneficiary whether or not the supplier uses a central billing office. (This means the site where the company met with the beneficiary or received the beneficiary's call.) All claims for the services of suppliers from branch offices or sales/rental outlets outside of the carrier's service area must be transferred to the appropriate carrier for processing.

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(These suppliers using a central billing office are not required to maintain uniform charge structure for all areas where they have offices.)

Note: Claims for all services furnished by a supplier on or after July 1, 1977, and all previously diaried claims for rentals must be submitted to the carrier having jurisdiction of the area where the service was furnished. *DME purchases that were diaried before July 1, 1977, and are still active accounts are retained until the accounts are closed by the carrier having jurisdiction before July 1, 1977.*

EXAMPLES OF MULTI-CARRIER JURISDICTION

EXAMPLE 1. The ABC Co. has a central office in Massachusetts with branch offices in Philadelphia, Trenton, New York City and Miami, with a warehouse in Massachusetts. The company's policy is to bill routinely from each branch office.

a. A beneficiary residing in New Jersey purchases (or rents) a wheelchair from the ABC Co.'s Trenton branch office. The wheelchair may be delivered to the beneficiary or his representative at the branch office, to the beneficiary's home or to a relative's home by the branch office, or shipped from the Philadelphia branch office or from the warehouse in Massachusetts. The Trenton office handles the billing and *the carrier with jurisdiction for processing the claim is the New Jersey carrier.*

b. A beneficiary residing in New Jersey purchases (or rents) a wheelchair from the ABC branch office in

Philadelphia. The wheelchair may be delivered to the beneficiary for his representative at the branch office, to the beneficiary's residence, or shipped from the Trenton office or from the warehouse in Massachusetts. Billing is handled by the Philadelphia office. *The carrier with jurisdiction for processing the claim is the Pennsylvania carrier.*

3c. A beneficiary whose residence is in New Jersey vacations in Miami and finds it necessary to purchase (or rent) a wheelchair from the ABC branch office in Miami. The wheelchair is delivered to an address, not his residence, by the Miami branch office. The beneficiary uses it in Miami and returns home to New Jersey, still requiring use of the equipment. Billing and claims preparation is performed by the Miami office. *The carrier with jurisdiction for processing the claim is the Miami carrier.*

EXAMPLE 2. The XYZ Co. has branch offices in six states but maintains a central billing office in Massachusetts which handles all billing and claims preparation on assigned claims for sales and rentals by all of its branch offices.

a. A beneficiary residing in Chicago, Illinois, purchases (or rents) a hospital bed from the XYZ Co. branch office in Chicago. The bed may be supplied to the beneficiary of his representative from the Chicago office, from another branch office in Michigan, or from the warehouse in Massachusetts. The bill is prepared by the Massachusetts billing office. *Jurisdiction for claims processing is the responsibility of the carrier for the Chicago branch office.*

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b. A beneficiary residing in Massachusetts visits a friend in Queens and requires the use of a wheelchair, which is purchased (or rented) from the Manhattan office of the XYZ Co. The wheelchair is delivered to the Queens address from a warehouse in Massachusetts. The beneficiary uses the wheelchair in Queens and returns home to Massachusetts still requiring the use of the chair. Billing is handled by the Massachusetts office. *The carrier with jurisdiction for claims processing is the carrier serving Manhattan.*

EXAMPLE 3. The DME Supply Co. has one office in Philadelphia. The company does not maintain separate branch offices in other states but hires (or commissions) representatives or salespersons who operate over a wide area, crossing State lines. Orders for DME are submitted by the representatives to the Philadelphia office which handles shipping and billing on all transactions.

a. A Beneficiary with a residence in Indiana is confined to a home for the aged in Ohio and requires covered DME which the home does not supply. A representative from the DME Co. calls at the home and arranges for rental of equipment prescribed by the physician. The equipment is delivered to the beneficiary at the home in Ohio from the Philadelphia office which also handles billing and submits claims on behalf of the beneficiary. *The carrier with jurisdiction for claims processing is the Ohio carrier.*

b. A beneficiary residing in Indiana is about to be released from a skilled nursing facility in Ohio where he has been using DME supplied by the facility. Since continued use of the DME will be necessary, a

representative of the DME Supply Co. calls at the facility in Ohio and arranges with the beneficiary for sale (or rental) of the prescribed equipment. The order is sent to the Philadelphia office which arranges shipment to the beneficiary's home in Indiana, and also handles the billing arrangements. *The carrier with jurisdiction for processing the claim is the Ohio carrier.*

c. A beneficiary residing in Indiana is about to be released from a skilled nursing facility in Ohio where he has been using DME supplied by the facility. After the beneficiary returns home, the physician prescribes continued use of the equipment. A representative of DME Supply Co. calls at the beneficiary's home in Indiana, arranges for rental (or sale) of the equipment. The equipment is shipped from Philadelphia which also handles billing. *The carrier with jurisdiction for claims processing is the Indiana carrier.*

(See § 4105.8 for processing instructions for claims from suppliers using central billing.)

* * *

§ 3110. TRANSFERRING REQUESTS FOR MEDICARE PAYMENT (in pertinent part)

If the request for Medicare payment was misdirected, the carrier reroutes it, after extracting the information needed to advise the sender that his claim was misdirected and that it is being forwarded to the proper servicing carrier.

* * *

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§ 4011.8 *Item 8: Name and Address of Physician or Supplier.* (in pertinent part)

> Name and address information is furnished to help carriers determine whether the physician/supplier of services can qualify for benefit payments, and as an aid in determining jurisdiction and referring the claim to the servicing carrier where appropriate. In assignment cases, the address is used for payment purposes. (See § 3047 and § 8204 where group or clinic bills in its name on behalf of physician.)
>
> * * *
>
> The telephone number item is provided to facilitate developmental contact with the physician/supplier.
>
> * * *

§ 4105.5 *Claims From Suppliers With Central Billing Operations For Branch Offices in More Than One Carrier's Jurisdiction.*

> Jurisdiction for processing of claims from suppliers with branch offices or sales/rental outlets in more than one carrier's jurisdiction, that bill from a central office, is determined according to the instructions in § 3102.B
>
> Suppliers using central billing operations must identify the office or sale/rental outlet location from which services were furnished (or durable medical equipment rented or purchased) in block 24 of the HCFA-1500 or in block 13 of the HCFA-1490 or on the supplier's bill. The carrier receiving the claim must develop the location of the sale, rental or other services if this information is not shown.

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When claims from a local supplier *routinely* show sales, rentals or other services to beneficiaries outside the carrier's normal geographic jurisdiction but the supplier does not furnish an address other than the billing office location on the claim form, make a contact with the billing office to determine whether or not this supplier has established a sales or rental outlet location outside the carrier's jurisdiction. (A supplier doe does [sic] business outside the carrier's area solely through catalogue sales may routinely show beneficiary addresses outside the service area.)

Make educational contacts with suppliers to insure that adequate information is always furnished on claims or bills, to minimize development and assure timely processing of claims.

§ 4105.8 *Claims From Suppliers With Central Billing Operations For Branch Offices in More Than One Carrier's Jurisdiction.*

Jurisdiction for processing of claims from suppliers with branch offices or sales/rental outlets in more than one carrier's jurisdiction, that bill from a central office, is determined according to the instructions in § 3102.B.

Suppliers using central billing operations must identify the office or sale/rental outlet location from which services were furnished (or durable medical equipment rented or purchased) in block 13 of the HCFA-1490 or on the supplier's bill if Part 2 of the HCFA-1490 is not completed. This includes identification of the location on claims from sales/rental outlets located in the same carrier jurisdiction as the billing office. The carrier receiving the claim must

develop the location of the sale, rental or other services if this information is not shown.

When claims from a local supplier *routinely* show sales, rentals or other services to beneficiaries outside the carrier's normal geographic jurisdiction but the supplier does not furnish an address other than the billing office location on the HCFA-1490, a contact must be made with the billing office to determine whether or not this supplier has established a sales or rental outlet location outside the carrier's jurisdiction. (A supplier who does business outside the carrier's area solely through catalogue sales may routinely show beneficiary addresses outside the service area.)

Carriers should make educational contacts with suppliers to insure that adequate information is always furnished on claims or bills, to minimize development and assure timely processing of claims.